CHILD SEXUAL ABUSE
NEEDS ASSESSMENT
AND
INTERVENTION MODEL

Executive Summary

Province of Prince Edward Island

December 1991

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This study had its origin in 1988 when Rix Rogers, Special Advisor on Sexual Abuse to the Minister of Health and Welfare Canada, came to P.E.I. on his cross-Canada consultations on child sexual abuse (CSA). Following that consultation, a proposal was submitted to Health and Welfare Canada for funding of a needs assessment study with the goal of developing a rural model of service delivery to be tested on the Island. Funding was received in May of 1990 to do the study. The Department of Health and Social Services contracted with the P.E.I. Division of the Canadian Mental Health Association to implement the study.

A comprehensive assessment of the response to, and intervention with, sexual abuse victims was conducted identifying and measuring the met and unmet needs of victims, their families, and the workers, agencies and institutions who respond to this problem. It was recognized that there was not a comprehensive system of services in place to deal with child sexual abuse, and the main purpose of this study was to give direction in the development of needed programs. It was not meant to be an evaluation of services but rather an examination of what is "needed" in order to provide an efficient and effective service to victims and families.

Priorities were established in the course of conceptualizing the study:

(1) The central focus of the study was on identifying the needs of victims of abuse and on the requirements for support and empowerment.

(2) Families were seen as extremely important in the victim's experience, and represented a potential source of either support/empowerment or further victimization.

(3) The system of services that responds to sexual abuse was the focus of the study; to assess how well the services meet the needs of victims, and what the workers and agencies themselves require to respond to victims therapeutically and effectively.

(4) The rural context of service delivery was important in understanding the needs of victims, in developing therapy programs, and in delivering services.

Background information for formulating the proposal was obtained from two principle sources: a comprehensive literature review and extensive interviews with service providers involved with child sexual abuse.

GENERAL APPROACH TO METHODOLOGY

The study centered on the experience of victims as they go through the system and on the systemic nature of the intervention. In addition, emphasis was placed on drawing upon a variety of sources and different types of information in order to help understand the intervention experience of the child and family.

As part of the needs assessment, an advisory committee was established with a membership from both government and community groups. The committee provided expertise, advice, and experience in regards to child sexual abuse and assisted in coordination of the study. As the study progressed, the committee became involved in focusing on needs to be addressed and defining main ingredients needed in the model.

The main groups studied in the needs assessment included:

(1) Victims;
(2) Families;
(3) Offenders;
(4) Staff/personnel;
(5) Agencies;
(6) Interagency system;

METHODS

The following were the methods used to collect information:

(1) Interviews with victims and families;

(2) Interviews and questionnaires for offenders, counsellors, guidance counsellors, police, justice staff, and administrators;

(3) Data schedules filled out by Child and Family Services (CFS) workers.

Information about victims and families was collected through interviews with them, and other perspectives were obtained from therapists, CFS workers, guidance counsellors, professionals and agencies. As well, information about the needs of the service system was collected from a number of sources including administrators, CFS workers, therapists, police and so on. Further data was obtained through a literature search.

FINDINGS

PROFILE OF CASES

An analysis was completed on past and present sexual abuse cases within CFS to identify needs and trends in services. A total of 79 cases were reviewed covering the period from 1986 to 1989.

1986-1989 - 79 Cases

Female Victims:	85%
Male Victims:	15%
Ages - 0-4 Years:	15%
- 5-10 Years:	35%
- 11-13 Years:	20%
- 14-17 Years:	30%
Intrafamilial Offender:	71%
Biological/Step-Parent:	33%
Extrafamilial Offender:	29%

Complaints to Child and Family Services of child sexual abuse from June of 1990 to May of 1991 were reviewed. There were 90 complaints during that period, with 43 cases (48%) being validated at the time of the study. Eighty-six percent of validated cases were female and 14% male. Twenty-five percent were under the age of five, 25% 6 to 10, 50% 11 to 17. Thirty-eight percent involved intrafamilial abuse with 22% being parental.

Based on national trends, one might expect three to four hundred incidents of sexual abuse on P.E.I. in any one year. As reporting increases, the number of victims and families that the system must respond to will increase accordingly. This would mean, using current cases, that between 125 and 200 complaints will have to be investigated in any one year. Given the varying degrees of risk, services will have to be made available to those victims, members of their families, and the offenders.

GENERAL FINDINGS

(1) Victims:

The first aim of intervention is to do no harm. Sources of harm potentially exist on several levels: (1) mandates, protocols and agency practice; (2) knowledge, experience and training; and (3) issues of worker awareness and focus. To successfully assure that the system does no harm, it is essential that problems on all these levels be examined and addressed.

So much of intervention with children understandably centers on the need to protect them. It is imperative that the first priority in intervention be the assurance of children's safety from further abuse. But the findings of this study suggest the strong need to balance safety with the desire children have to control their lives. This is especially true with sexually abused children. For these children, powerlessness is at the heart of their experience as victims.

It is apparent that children first require a voice in the system of intervention. Opportunities need to be created within the intervention system where these voices will be welcomed and heard. Sympathetic adult advocates, or groups of children, may be useful in this process.

The essence of what is needed is the development of a system of response centered on the needs and experiences of children. To accomplish this, the child's voice must now be given more weight than the voices of powerful adults with their own agendas in the child's life. This is the basis of empowerment and recovery.

(2) Families:

The needs of families were studied from a number of perspectives including direct interviews with 26 families, information from therapists, case records, agency workers such as Child and Family Services, Mental Health, Victim Services, and from literature review.

Some of the key areas identified to be addressed include:

(1) Involvement of parents in the process;
(2) Information-sharing with parents;
(3) Decision-making for parents;
(4) A more organized, coherent and consistent process;
(5) Improved training and expertise at all levels;
(6) A more sensitized, child-focused service delivery;
(7) Availability of specialized therapeutic resources.

There was special recognition of the need of the system to involve parents in an active role in the intervention process. This was seen as especially important in cases where the offender was the spouse of the supporting parent. There is a need for special services with vigorous outreach and understanding to assist in these situations. A wide variety of services may be needed for families including support, information, involvement, housing, income and therapy to name some.

(3) Offenders:

Offenders were not to be a major focus of this study; however, the potential for the offender to impact on the present and future experience of the victim became evident as the study progressed. It became apparent that a system that wished to provide for the needs of victims and families needed to develop an approach for the management and, if indicated, for the treatment of offenders.

Offenders were studied from a number of perspectives including direct interviews and questionnaires completed by offenders, case record information, questionnaires filled out by CFS workers, probations, questionnaires filled out by directors of Sex Offenders Programs across Canada, and through literature review. A number of issues were identified to be addressed including philosophical approach to offenders, overall coordination of services, training for all levels, available assessment and treatment services throughout the Province, and the ability for long-term monitoring and management.

(4) Staff/Personnel:

A survey of law enforcement officers in Prince Edward Island indicated that there were particular needs in training and case experience for both members of the RCMP and municipal departments. Training should reflect the distribution of officer availability in both rural and urban areas. Training should be of joint nature with social workers.

A survey of social workers in the Department of Health and Social Services indicated the need for training in specific areas, especially in cases involving denial of the allegation and high risk. They also indicated the reporting of abuse and the flow of information between agencies as particular areas of concern.

Judges in the Provincial and Supreme Courts were interviewed and they felt that the major means of helping victims in court was the presentation of "good" evidence. Judges require more information on many areas, especially treatment effectiveness. Young offenders is a particular problem area.

There was a general consensus that there was a need not only for more coordination and organization to the system of intervention but also for an increase in the quality and quantity of resources. It was felt that there was a need for training to improve skills of workers. In addition, the provision of services to victims of CSA and their families was time intensive and often made difficult due to limited resources and overall high caseloads and work demands.

(5) Agencies:

Before there is any organized response to children who are sexually abused, a number of agency components have to be addressed:

(1) In the area of law enforcement, issues of specialization, information flow, protocols and the distribution of specialized staff;

(2) In the Department of Health and Social Services, the major needs areas include the nature of protocols, policies on decision-making, workloads, and external coordination;

(3) In Victim Services, the major need is a more defined role in child sexual abuse and modification of referral patterns and information flow;

(4) In volunteer support agencies, the key need is a definition of the role they have in a system of response and the maximum use of available resources;

(4) In Mental Health Services and private agencies, the major need areas are availability of trained staff, nature of services and referrals;

(5) In the area of guidance counsellors in the schools, the need to examine the possibility of a greater role for schools in responding to child sexual abuse.

A half-day forum was held with representatives from "special needs" groups which included representatives from the day care sector, early childhood education, foster care and social work. The issues and concerns that were raised during this meeting are as follows:

(1) Problems with accessing resources;
(2) The process is not child centered;
(3) Feedback and support to those reporting the abuse;
(4) Need safe ways for children to report abuse;
(5) More education about sexual abuse.

Even though the difficulties that service providers experience are corrected and the internal agency difficulties in terms of goals, structures and processes are improved, an adequate system of response to victims and their families is not the result of a number of independent, adequate agency responses. It is the sum of their adequate interdependent responses which collectively contribute to meeting the needs of a child who has been sexually abused.

(6) System and Agency Response:

One of the major requirements in the delivery of services to a victim and their family is that it be a coordinated process. Coordination is a means by which we accomplish goals. The question that has been asked throughout this assessment has been, whose goals has the present scheme of intervention really met? The data and observations in this assessment indicate that to some extent they haven't been the victim's very frequently. In fact, the question arose, was anybody's goals actually met?

This assessment began with the premise that there was a system of intervention with a series of complex components - people, agencies, processes, structures, information flow, and corrective mechanisms. We quickly observed that there was, in the empirical sense, no system. In fact, many of the components of a system of response were not present, nor were there some of the preconditions for a system of response to children.

The study observed a number of fragmented services with very distinctly independent goals, many of which did not include responding to children who have been abused. Many agencies already recognize the problem; however, they do not recognize that they are, to varying degrees, dependent on each other, not only to fulfill their own mandates but also to accomplish something in an effective manner for a child who has been sexually abused.

The first requirement is for goals to be integrated into each agency's goal structure; second, to devise and develop a system which can respond to these goals; and third, to devise means by which they can more effectively integrate and coordinate their actions with victims. The problem which needs to be addressed is how to manage all the separate components which have different functions and roles with the child even if they were coordinated in their efforts.

It became apparent that a manager was needed to monitor quality, access, linkage to services, and equality of intervention. This role is needed to identify the many needs, connect them to services and monitor outcome and accountability. In addition, there is a need to identify problems which may occur in programs and find ways to correct them.

The solution is to focus on all information, experience, and knowledge at one point - "a team of decision-makers" who best know their areas of expertise and who could mutually adjust their plan to fit the needs of the child. They could jointly review and modify their actions, share some of their expertise and carry out interdependent actions. They could create an overall plan for intervention and then a case manager could coordinate its implementation and evaluate its progress.

In order for the case manager and the team to be effective, it is necessary to have interagency cooperation. This will require:

(1) Resources;
(2) Sharing of resources;
(3) Some degree of joint planning and programming;
(4) Formal agreements;
(5) A defined system of communication;
(6) A working degree of consensus on roles and responsibility,
(7) Mutually accepted goals;
(8) Standardized referrals and other procedures;
(9) Conflict resolution.

It requires a "real system" - one with a structure and a purpose, designed for the child who has been sexually abused.

MODEL DEVELOPMENT

The needs assessment identified a number of issues, problems and gaps, and the need to develop an intervention model for future services. The type, nature, and degree of need of family and victim and the subsequent intervention by the system has been identified as complex due to: (a) the nature of the various mandates involved, (b) the intervention into the intimate lives of families and victims, (c) the nature of specialization, and (d) the overall need for support.

The solutions to these needs require considerable levels of interagency negotiation and consultation to reduce the complexities and to assure a more efficient and effective intervention system. As a first step, the study is recommending that *negotiations between the main agencies involved in the provision of services need to occur.* The proposal for model development encompasses a highly specific focus and direction with the recommendation that the Provincial Government review the feasibility of the model and begin negotiations with Health and Welfare Canada for a more detailed funding package for implementation and testing of this model.

One of the key areas that needs to be addressed in any model of service delivery is a focused philosophy. The philosophy which is being proposed focuses on such things as a child-centered system, a cooperative, continuous and collaborative approach, accountability for offenders, and the use of community resources.

In addition to philosophy, the major goal/purpose of the intervention model is to provide an intervention system for child sexual abuse victims and their families within a rural context:

(1) To achieve safety from further sexual abuse and abusing situations;

(2) To achieve healing for the effects of the abuse situation;

(3) To achieve self-confidence, power and control over their lives to prevent further victimization;

through an integrated child-centered system of intervention.

In order to reach the overall purpose of the model, a number of goals need to be obtained, including:

(1) To provide a child-centered and sensitized response to the needs of victims of child sexual abuse and their families which makes the child safe and does not revictimize;

(2) To provide means to adequately respond to the trauma of the abuse experience and to other problems in their lives;

(3) To provide a network of support to the child who has been sexually abused to assist in dealing with the formal and informal system of response;

(4) To provide means of maximizing children's (and families') sense of control over the intervention in their lives;

(5) To provide the victims and families with a system of services which are available, accessible, continuous and accountable.

As indicated, the study is recommending *that there be established a steering committee to coordinate and legitimize initial action steps.*

The study has developed a detailed outline for Provincial and Federal Governments to consider and further develop for testing. The model emphasizes the effective use of current resources and is designed to maximize these programs and services. At the same time, this does not necessarily preclude the potential need for new or improved levels of resources for the system to operate effectively. The study is proposing that an effective model of intervention for child sexual abuse can be realized with the input of the following:

(1) Training;
(2) Coordination;
(3) Support systems;
(4) System feed-back/advocacy;
(5) Specialist utilization of assessment/treatment services;
(6) Special technologies.

The project will propose not only to develop and demonstrate a model of rural delivery but also to develop resources or modules which will provide a blueprint on how to produce such programs in other areas.

It is recommended that the model go through several phases including a pre-funding phase which will involve the review of the needs assessment and submission of a formal proposal to Health and Welfare Canada, an implementation phase which will involve the implementation and testing of the model, and a final phase which will include research analysis and report completion.

The complete report totals 386 pages plus two appendices. Copies are available, in whole or in part, upon request as follows:

Prices:

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Report Body	$10.00
Appendix A (informants' information)	$ 3.00
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Prince Edward Island

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AND
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A Study Conducted By

Canadian Mental Health Association / P.E.I. Division

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Submitted To

The Minister
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Province of Prince Edward Island

This model and needs assessment was contracted from the Government of Prince Edward Island and Health and Welfare Canada, Mental Health Division, under contract (File Reference Number 6773-2-29)..

The following analyses, interventions and recommendations are those of the research group. They are the responsibility of the research consultants and do not necessarily reflect the views of Health and Welfare Canada, the Government of P.E.I., and its Departments, or the Canadian Mental Health Association / P.E.I. Division.

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The work of the Advisory Committee is described in the body of the report but here we would like to personally thank them for all the time and effort they gave to this project. For their comments and feedback at various stages and their willingness to be available at any time to help in any way, and especially the time and energy spent in the sub-committees, we deeply thank Stuart Andrews, Rona Brown, Yvette Blanchard, Cheryl Cannon, Gwyn Davies, Richard Doan, Brenda Lee Doyle, Helen Durie, Dianne Griffin, Sandy MacDonald, Mary Beth McMillan, Ellie Reddin, Ann Sherman, Brian Stevenson, Bert VanCook, Marie Walsh, and Cindy Wedge. Special thanks to Rona Brown, Brenda Lee Doyle, Ellie Reddin and Brian Stevenson for their long hours and diligent work in the coordination sub-committee. Many of their recommendations have become part of the proposed intervention model.

This report would not have been possible without the skilful and sensitive involvement of our four project interviewers: Mari Basiletti, Gwyn Davies, Angela Gates and Gloria McInnis. They were responsible for almost all interviews with children, parents and adult survivors and created a supportive and responsive environment in which our respondents often shared very personal and very difficult moments in their lives. The frank and compelling nature of our respondents' statements clearly reflect their trust and comfort with these four women. Mari, Gwyn and Angela also did an excellent job with the arduous responsibility of carrying out the thematic analyses of the interviews for all three groups of respondents, and writing narratives that clearly communicated the experiences of interviewees to the investigator (D.M.) who compiled the material and wrote the report section on children.

Many therapists, Child and Family Services workers, Victim Services workers, municipal police officers, members of the RCMP, Crown attorneys, judges and guidance counsellors spent a great deal of time completing questionnaires for us. We would like to thank everyone who filled out a form either about the victims of sexual abuse or about their own work in this area. We appreciate your honesty and candor in responding to our questionnaires. In addition to filling out forms, interviews were also conducted with a sample of these people. We are very grateful to the eight therapists who gave so willingly of their time and their experience in lengthy interviews and helped us to develop a perspective on the therapeutic process. We would like to thank those social workers, municipal police officers and members of the RCMP who also agreed to be interviewed with a particular thank you to Chief Superintendent John Moodie, the commanders of RCMP detachments and the chiefs of the municipal police departments. Thanks is also extended to those justices of both the Supreme Court and the Provincial Court of Prince Edward Island who gave their time for interviews.

Accessing children, families and survivors for interviews was a time consuming process and yet was a vital part of this project. To all those therapists, Victim Services workers and social workers who participated in the lengthy and complex access procedures, a heartfelt thank you.

There were many agencies and administrators of these agencies who provided valuable assistance throughout the term of this project. We are grateful to all of the administrators and staff of Child and Family Services, particularly Ken Barter and Yvette Blanchard. We are also grateful to all of the Regional Directors of CFS who were supportive of this project and who encouraged their staff involvement. We would like to thank the administrators and staff of Mental Health Services, Anderson House, Rape and Sexual Assault Crisis Centre, Catholic Family Services Bureau and Protestant Family Services Bureau for their help and support.

Special thanks goes to Sandy Simpson and Jill Lightwood for their ongoing help and support throughout this needs assessment. We are grateful to Sandy Bentley and Pam Forsythe who were helpful in getting the project underway in the very beginning.

In this technological age, computers are a necessity especially in a project that involved a great deal of data. Of course computers don't always cooperate with the user and sometimes the user isn't completely familiar with the programs so assistance is frequently needed. This assistance was willingly and capably provided by the Director and programming staff of the University of Prince Edward Island Computer Centre and to them goes sincere thanks. A special thank you to Helen Clow, MIS Coordinator for the Department of Health and Social Services, who gave us so much help and was so patient with our impossible demands and to Wendy Platts for her valuable assistance.

In a project as complex as this one, there are bound to be several individuals who give that little extra to help reach the goal. This project was no different and a deep and sincere debt of gratitude is owed to three individuals whose commitment to the project went above and beyond their designated roles. Those wonderfully committed people are Rona Brown, Mari Basiletti and Brenda Lee Doyle.

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Finally, our greatest thanks and deepest debt is to the real "authors" of major sections of this report; the children, parents and adult survivors who were kind enough and courageous enough to share their experiences with us. Their voices are at the centre of this report and belong at the centre of any system of intervention that emerges from this work.

While the study is the product of the entire research team, it was of course necessary to have some division of responsibility in carrying out such a complex project. Bill Lawlor, Director of Program Services, Mental Health Division and the principal investigator, was responsible for the work done with the families and offenders. Don Mazer, a clinical psychologist and research consultant to the project was responsible for the work with victims, adult survivors, therapists and guidance counsellors and developed and managed the qualitative data analysis. Joe Kopachevsky, an organizational sociologist and research consultant to the project was responsible for the work done with case records, Social Services, police (both Municipal and RCMP),and organized the quantitative data analysis. The work with Justice was done jointly. Katie McInnis was the project coordinator and had the responsibility of managing the entire project, maintaining liaison with supporting organizations and the community and trying to bring together these different sources into the final report.

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I. INTRODUCTION

I.1 HISTORY OF THE CURRENT PROPOSAL

In the early 1980's, due to increasing professional and public awareness of the nature and incidence of child sexual abuse, more and more cases began to be identified. The impact of these demands soon overwhelmed the emotional,technical, human and material resources of the local Social Service system. The initial strides that were made in the area of identification were not matched equally in the area of solutions. The police and particularly the child welfare agencies felt the brunt of the initial pressures.

Across North America there were numerous research projects, therapeutic interventions, an prevention programs developed to attempt to deal with this immediate crisis. Services on Prince Edward Island focused on similar concerns. Many of the models that were being developed emerged from more centralized, urban areas and were of questionable applicability to Prince Edward Island. Along with questions about the effectiveness of existing models, many appeared beyond the means or capability of a more rural or remote area, because they required highly specialized professional input with a considerable expenditure of time and resources. As such, the question to be addressed was, "How does a province such as Prince Edward Island provide effective intervention into the problem of child sexual abuse considering these limitations?"

In 1986 when Rix Rogers came to Prince Edward Island, it was decided that the Province would request funding from Health and Welfare Canada to do a needs assessment in the area of child sexual abuse, develop a model specific to a more rural context, and test that model on Prince Edward Island with the intention of evaluating its applicability to other parts of Canada. A submission was made in the spring of 1988. Through further consultation with Health and Welfare Canada, it was decided that the submission should be divided into two parts including a needs assessment and model development which then could be evaluated for implementation and testing. A proposal was submitted in the fall of 1988 for the first stage of this project. Through further consultation with Health and Welfare Canada, it was decided that the proposal could be further developed and formulation funding was made available in early spring of 1989. The proposal for a needs assessment and model development is currently being submitted. Once completed, a further proposal will be submitted for the model's implementation and evaluation.

The sexual abuse of children represents a pervasive and crucial social problem. Understanding this problem and developing an effective response to it are extremely complex for two major reasons. First, many people are involved in the problem. There are the victims and families that are more often than not profoundly and negatively affected by the experience; the offenders, sometimes victimized during their own childhood, whose behaviour and attitudes are so difficult to change; the numerous legal, social service and mental health professionals who become involved in intervention with the problem; and the members of the larger community who reflect values and attitudes that contribute to the sexual abuse problem.

Second, the process of intervention with sexual abuse is extremely complex. There are many aspects of our social response to sexual abuse, and determining which areas are in need of the most immediate attention is a subject of considerable debate. All of these processes and the persons involved in them required attention in dealing with the problem of sexual abuse. But, due to the scope and complexity of the problem, the development of a focus of attention was required. Such a focus was determined by what we are capable of doing at present and by what we evaluate as the most pressing needs in responding to sexual abuse.

The aim of this study was to conduct a comprehensive assessment of response to and intervention with sexual abuse victims with the aim of identifying and measuring the met and unmet needs of victims, their families, and the workers, agencies, and institutions who respond to this problem. The needs assessment is not meant to be an evaluation of services, but rather an examination of what is "needed" in order to provide an efficient and effective services to victims and families. It is recognized that there is not a comprehensive system of services in place and that the purpose of this study is to give a direction in the development of needed programs.

There have been several values and priorities that we have developed in the course of conceptualizing this problem on Prince Edward Island.

(1) The central focus of the study was on identifying the needs of the victims of abuse, and on what is required to provide them with support and empowerment. Many different persons and agencies "touch" the victim, and we wanted to know about how these "touches" affect the victim's experience.

(2) Families are seen as an integral aspect of the victim's experience, and represent a potential source of either support/empowerment or further victimization. We wanted to learn about what families need in order to provide better support to victims.

(3) We focused on the system of services that responds to sexual abuse to assess how well they met the needs of victims, and what the workers and agencies themselves required in order to respond to the needs of victims more therapeutically and effectively.

(4) We were mindful of the fact that sexual abuse is a social problem, and that social values and attitudes contribute to its occurrence, its extensiveness, its effects and to victims' reluctance to disclose.

(5) We believe that the rural context is important in understanding the needs of victims, in developing therapy programmes, and in delivering a system of services.

(6) We recognized that identifying the needs of victims and families by studying only those cases that are in the services system may not be representative of the distribution of intrafamilial and extrafamilial cases in the population. The needs of these two groups might be quite different. Our aim was to ultimately develop a response to

sexual abuse that is more suited to all victims.

In a small, rural context like P.E.I., the actual number of cases for study is not large, and the potential for comparative analysis of data is somewhat limited. In order to accomplish the goals outlined above, we utilized a multimethod approach to data collection. (1) Existing psychometric instruments, and scales developed for this study were employed in a variety of contexts, e.g., as a means of assessing some of the effects of abuse and the process of intervention. (2) Major emphasis was placed on interview methods that provide victims and those closest to them with the opportunity to give voice to their own experience. As Mathews (1989) puts it, "Most important of all is the need to involve the victims themselves in the design and implementation of new initiatives so that they may be empowered to shape and control their healing process" (p. 3). Interviews with others, such as family members and service workers enabled us to learn about their experiences and needs more directly. (3) Key informant interviews with a range of respondents provided a variety of perspectives on the process of intervention and service delivery useful in establishing unmet needs. (4) Records of past cases were systematically examined to obtain a profile of the "treated" population on P.E.I.; and to learn about general patterns of service utilization. (5) Community forums enabled us to learn about the attitudes and perspectives of particular groups and how these might affect the disclosure of abuse and the response to it. (6) In some instances, survey instruments enabled us to obtain a general profile of the needs of particular groups (e.g., offenders).

I.2 INCIDENCE AND INTERVENTION:

In 1985 the Prince Edward Island Chapter of the Child Welfare Association attempted to document the incidence and types of child sexual abuse on Prince Edward Island. In this study (the Bulger Report), information was obtained from police records within P.E.I. based on founded reports of sexual assault. There were a total of 168 founded reports of sexual assault for all ages during 1983, 1984, and 10 months of 1985 inclusive. Of these, 51 were against adult victims and 117 were against children age 17 and younger. The study identified 101 investigations under the age of 16, with a total of 123 victims. Of these cases 51% represented intrafamilial abuse and 4% were extrafamilial abuse. Cases increased from 2 in 1983 to 44 in 10 months of 1985, representing an 82% increase in reported cases in two years. In other data gathered for the years 1988-89, there were 110 victims of child sexual abuse on the child welfare caseloads in Prince Edward Island.

A survey was done on all cases of child sexual abuse referred to Community Mental Health from 1985 through six months of 1989. There were a total of 137 victims referred for treatment, 62 under the age of 12. Approximately 5% of those were living in the smaller rural areas, with 41% living around cities or towns. Sixty-four percent were intrafamilial abuse with 37% extrafamilial.

I.3 RURAL SERVICE DELIVERY SYSTEMS

Rural delivery systems have been the subject of attention for many years (Warren, 1955). Backrach (1977) and Solomon (1979) among others have identified a number of factors unique to rural areas and mental health services that constrain service delivery; availability, consistency, staffing, funding, distance, and training are the most notable. Others have noted that there is considerable difficulty in making service or intervention decisions in rural areas given the unique community dynamics of rural areas (Abou-Ghorra, 1980; Bufferum, 1984). It is felt by the needs assessment group that whatever barriers are present in "everyday" delivery of mental health services, they are severely heightened by the nature and implications of child sexual abuse. If child sexual abuse strikes and challenges the very fabric of rural communities, then it will significantly influence services in those rural areas. Hill (1989) has noted that rural and remote areas have different needs from urban areas in terms of staff, awareness and training in the delivery of services to victims of sexual abuse. It is then felt that meeting the needs of victims and families during intervention and formulating a therapeutic response in terms of service availability while recognizing rural community dynamics requires very complex and critical decision-making on the part of intervenors and service providers.

In the last twenty years, there has been an increasing trend toward community empowerment. This raises the concern of "community primacy" in decisions regarding entry of services and service delivery in rural areas. In fact, some have argued that community-specific entry and service models may be more appropriate for rural areas. In fact, they may be mandatory when considering services to the victims and families of child sexual abuse in rural areas due to the barriers that arise and the nature of rural support for victims.

I.4 WHY A NEEDS ASSESSMENT?

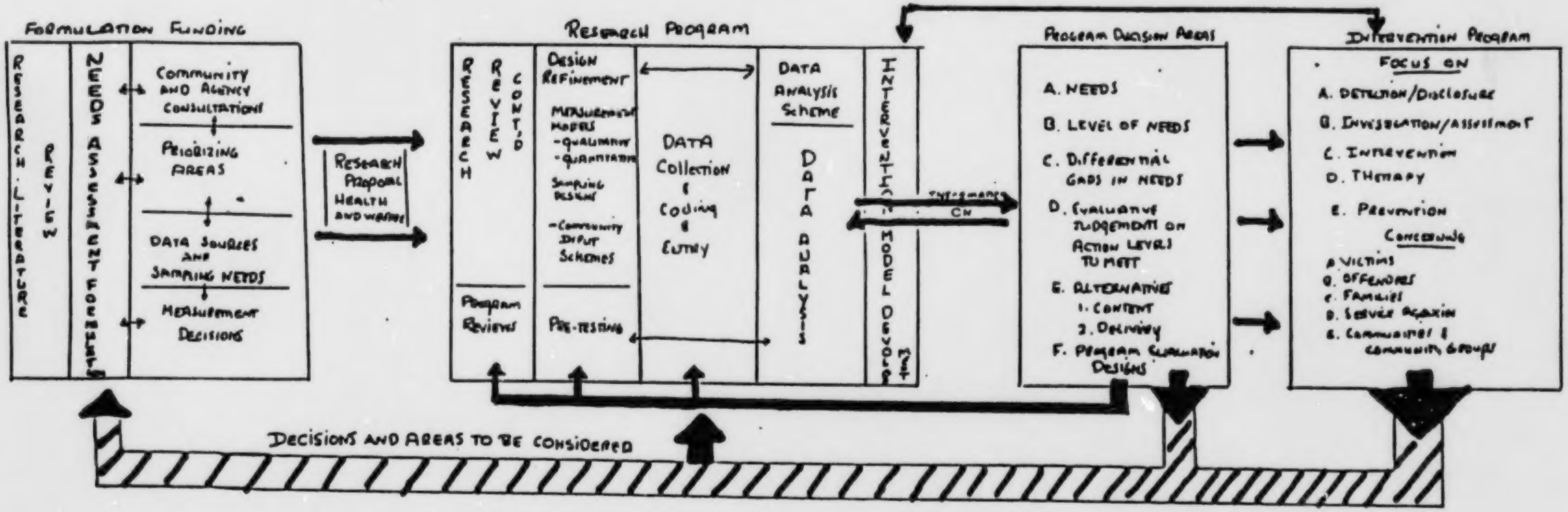
Needs assessments and their analyses are basic "evaluative" tools for decision-making in a variety of areas. The purpose of an assessment can vary from re-allocating resources to the planning of programs. In the P.E.I. situation, the major decisions revolve around the adequacy of service. Specifically, the concern is for adequate services which reflect needs in a rural and small urban context. Such a service needs to be cognizant of constrained service delivery and the probabilities of using non-governmental services and community support to assist victims of child sexual abuse and their families. A needs assessment in this situation should provide information not only on the current adequacy, but also information for actions which will enhance adequacy through a planned intervention. Likewise, decision-making on adequacy and information for decisions on the costs, feasibility and the potential impact of solutions is also required.

The State of the Art is such that there is no universal approach to needs assessment. Therefore, an assessment should be designed which reflects the specific concerns and decisions previously stated. Moreover, it should heighten the importance of particular systemic needs where suspicion may be stronger than initial evidence. If a systemic approach is chosen, then a multiple set of procedures should be put in place to access and assess all relevant information. Information, by itself, is an insufficient goal. Information which has a maximum amount of utility in decision-making is much more important. Although maximum utility may be desirable, budgetary considerations, time and the constraint of complexity of child sexual abuse has heightened our need for a focused and priorized needs assessment. Table 1.1 summarizes the focus of the P.E.I. systemic assessment. A systemic assessment had been chosen because of concerns (Finkelhor, 1988) in current research regarding victims and the harmful effects of processes on victims, the recognition of the possibility of clients "falling through the cracks" in the system's responses to victims, and the lack of a comprehensive understanding in the research literature of all processes as they relate to victims. If systemic decisions were required for adequate services, then a needs assessment was required which included the content, nature of response, and delivery of services. Most importantly, it was initially felt that the scope of the response to child sexual abuse victims required re-adjustment.

The first focus of the assessment, then, was to maximize systemic information, therefore, we placed the assessment of child sexual abuse by researching prevalence and incidence at a lower priority. This decision was initially made due to cost considerations and fears of local reaction to the process of estimating prevalence from other than agency records. Second, utility is a major concern in evaluating assessment information. Therefore data collection and measurement had to reflect the required planning decisions for an intervention. Third, the assessment was a tool for examining the adequacy of service, and the detection of systemic needs. Lastly, the assessment was required to reflect local realities in child sexual abuse and therefore, had to be priorized in its focus and use of assessment resources.

TABLE 1.1

P.E.I. CHILD SEXUAL ABUSE
FORMULATION, RESEARCH AND INTERVENTION PROGRAMS PLAN


FORMULATION FUNDING
RESEARCH LITERATURE REVIEW
NEEDS ASSESSMENT FORMULATS
COMMUNITY AND AGENCY CONSULTATIONS
PRIORIZING AREAS
DATA SOURCES AND SAMPLING NEEDS
MEASUREMENT DECISIONS
RESEARCH PROPOSAL HEALTH AND WELFARE
RESEARCH PROGRAM
RESEARCH REVIEW CONT'D
PROGRAM REVIEWS
DESIGN REFINEMENT
MEASUREMENT MODELS
-QUALITATIVE
-QUANTITATIVE
SAMPLING DESIGN
-COMMUNITY INPUT SCHEMES
PRE-TESTING
DATA COLLECTION & CODING & ENTRY
DATA ANALYSIS SCHEME
DATA ANALYSIS
INTERVENTION MODEL DEVELOPMENT
INFORMATION
PROGRAM DECISION AREAS
A. NEEDS
B. LEVEL OF NEEDS
C. DIFFERENTIAL GAPS IN NEEDS
D. EVALUATIVE JUDGEMENTS ON ACTION LEVELS TO MEET
E. ALTERNATIVES
1. CONTENT
2. DELIVERY
F. PROGRAM EVALUATION DESIGNS
INTERVENTION PROGRAM
FOCUS ON
A. DETECTION/DISCLOSURE
B. INVESTIGATION/ASSESSMENT
C. INTERVENTION
D. THERAPY
E. PREVENTION
CONCERNING
A. VICTIMS
B. OFFENDERS
C. FAMILIES
D. SERVICE AGENCIES
E. COMMUNITIES & COMMUNITY GROUPS
DECISIONS AND AREAS TO BE CONSIDERED

SCIACHNASKY (1:15/86)

I.5 FORMULATION PROCESS OF NEEDS ASSESSMENT

Process:

Background information necessary for formulating the proposal was obtained from two principle sources: (a) a comprehensive literature review; and (b) extensive interviews with service providers involved with child sexual abuse.

(a) Literature review. Computer searches of Psychological Abstracts, Sociological Abstracts and Government Documents (CODOC) used keywords to identify all literature relevant to sexual abuse beginning with 1975, and were supplemented by manual searches to identify the most recent sources. Approximately 1000 references were located through this process, and over 500 of these were obtained for immediate review.. (b) The interviews conducted during the formulation phase were seen as the beginning of an ongoing process of consultation that will continue during all phases of the project.

Interviews were conducted with administrators and workers from a variety of public agencies, working groups and organizations including: Child & Family Services, Division of Community Mental Health, Probation Services, Department of Justice, Interagency Committee on Domestic Violence, Rape and Sexual Assault Crisis Centre, Services for Adults Survivors of Sexual Abuse, and the Queen Elizabeth Hospital. One aspect of the interview process was the opportunity to follow a specific case through the intervention system from the viewpoint of several professional perspectives (case worker, victim's therapist, offender's therapist).

Advisory Group. A local advisory group comprised of representatives of different agencies and groups involved with services for sexual abuse and related problems will provide ongoing feedback to the project. This group was especially valuable in providing an ongoing link with those who are most directly in contact with the experiences of victims. In addition, since services of sexual abuse in a rural context like ours involves a wide variety of groups and agencies, the development of this group should facilitate the cooperation and communication that will eventually be required in the implementation of any systematic intervention programme. Representatives of the following groups will be included: Child & Family Services, Community Mental Health, Department of Justice, Protestant Family Services, Catholic Family Services, Rape & Sexual Assault Crisis Centre, Transition House and the RCMP.

I.6 GENERAL ASSUMPTIONS AND PRIORITIES

The preliminary information from records and interviews with selected service-providers, commenced our process of priorizing the focus of the needs assessment. It was apparent that slightly more than one hundred thousand dollars was available for actual data collection. Consequently, our decided systemic approach had to be internally priorized based upon the major actors in the process and the processes themselves. If not, the assessment would lack depth and the utility of the data obtained would not provide sufficient decision-making information for an intervention model. Our major concern was to maximize the utility of data given our major working assumptions.

In conjunction with the initial data gathering, literature review and use of professional experience, the general assumptions of the needs assessment had to be identified to hasten the process of formulation. Victims were identified as a prime concern and the services provided victims should at minimum do "no harm" to them and at least support them throughout the entire process. This naturally assumed that "good" services were provided to the client and the delivery supported the victim. The primary focus of the study was on the victim, with specific concerns being on the effects of the abuse and to the broad range of factors that may contribute to the abuse and to the severity of its impact.

To understand the effects of abuse and the needs of sexual abuse victims, it is important to recognize that such effects are not only a function of events surrounding the abuse itself, and of factors prior to the abuse, but of the social and institutional responses that follow disclosure (Haugaard & Reppucci, 1988). Such social responses may range from helpful, therapeutic and supportive ones to destructive and harmful ones that may exacerbate or recreate the emotional experience associated with the sexual abuse itself. The sources of such social responses are varied, and our attention is generally drawn to the post-disclosure reactions of family members, friends and the general community. The process of social systems intervention itself constitutes a vital aspect of the response to abuse victims with the potential for the same broad range of impacts. . The purpose of the present study is to understand the needs of sexual abuse victims through investigating the broad range of factors that contribute to its traumatic effects. Such effects may be conceptualized as either stemming from the abuse itself, and the "conspiracy of silence" (Butler, 1979) that often accompanies it, i.e., primary victimization, or to factors that precede the abuse such as family structure, relations or values. These primary effects may then be exacerbated by the social response to the abuse and to events following its disclosure, i.e., secondary victimization. The feelings associated with the abuse itself may be recreated or ameliorated by our response to it. Thus, a thorough assessment of the broad spectrum of victimization must look beyond disclosure to the investigation, legal and social services intervention, and to therapy to assess their effects on victims.

What are the major features of being a victim of child sexual abuse? How are the effects of child sexual abuse best conceptualized and understood? Finkelhor & Browne (1985) have suggested that the traumatic impact of sexual abuse can be understood as a function of four "traumagenic dynamics" that affect children's cognitive and emotional orientation as well as their self-concepts, worldviews and affective capacities. From this perspective, many of the global effects of sexual abuse, and the symptomatology associated with it stem from the following factors. (1) Traumatic sexualization - the precocious introduction of the child to a world of sexuality that she does not understand and for which she is emotionally unprepared; (2) Betrayal of trust - the abuser is usually someone in a position of authority, a person on whom the child is emotionally and/or physically dependent. (3) Powerlessness (or disempowerment) - the child may lose a sense of control over her life since she has to respond to the demands of a powerful other, and may feel helpless and that her needs are unimportant compared with others; and (4) Stigmatization - the sense of blame and responsibility a child might feel for the abuse and not being able to stop it may lead a child to feel like she is bad and different, and that others know this.

Finkelhor & Browne (1985) suggest that this model is useful in understanding how pre-abuse and post-abuse factors contribute to effects, as well as in understanding the impact of the abuse itself. Thus, the institutional and social response to disclosure may also reflect these traumagenic dynamics.

> A child who was relatively unstigmatized by the molestation itself may undergo serious stigmatization if later rejected by friends or blamed by family and if having been abused remains a focus for a long time. The dynamic of powerlessness is also greatly affected by a child's experiences subsequent to sexual abuse. If, for instance, a great many authorities become involved in the experience and a child is forced to testify, forced to leave home, forced to tell the story on repeated occasions, and subjected to a great deal of unwanted attention, this can also greatly increase the child's sense of powerlessness. But, if the child has a sense of having been able to end the abuse and obtain support and protection, this may greatly mitigate any sense of powerlessness that resulted from the experience itself (p. 539).

In order to comprehensively assess the needs of victims, it was necessary to learn about the social reactions of others in all contexts of the victim's experience, and about how the behaviour and interventions of others affect the victim. The effects of the abuse itself is in some ways inseparable from the effects of the social and institutional response to it. Even well intentioned efforts have the potential to reiterate the traumagenic dynamics of the abuse experience. Both support and empowerment appear to be critical aspects of a positive social response to abuse, but it might be very difficult for those charged with providing protection for the victim to also contribute to her sense of empowerment.

Thus, we were interested in assessing both broad general effects (e.g., symptoms, current functioning) and effects specific to the dynamics of sexual abuse, as they arise in the context of the abuse itself and the social and institutional response to it. For planned intervention with victims to be meaningful, both general and specific effects should be positively influenced by treatment and intervention efforts. And for this criteria to be met, first it should do no harm.

What We Can Learn From Victims. The inquiry into effects on victims of the abuse and subsequent social response and intervention was directed toward learning about the therapeutic needs that victims have, which needs are being well met by the current response to abuse, and the nature and extent of unmet needs of victims. Generally, we planned to learn about (a) what happened to the victim; (b) the effects of what happened, and her reactions to persons and events surrounding the abuse and response; (c) her view of what should have happened. Information was gathered within the context of structured interviews with victims conducted by trained interviewers, sensitized to issues of victimization and child sexual abuse. As much of the data about what happened (e.g., specific characteristics of the abuse experience, nature and timing of interventions) will be gathered from records. We hoped to learn about the victim's experience of the full spectrum of respondents and interventions in the context of the interviews, and to treat her as a "key informant" about what should have happened/be happening in an intervention system.

Families, on the other hand, could obviously play a supportive or non-supportive role during the process. It was assumed that services should assist families in a supportive role, rather than constraining them and instigating a non-supportive mode. Families were also assumed to be in many cases multiproblem families and this should be addressed. This study was interested in understanding the family factors which have the potential to positively or negatively impact on victims. The family's ability to provide the necessary supportive experience to the victim is affected by a number of pre- and post-disclosure factors. These factors had to be taken into consideration as they would reflect the types of needs families present as well as specific kinds of programs that may be required for intervention. The abilities of families to provide a supportive experience to the victim is a function of a number of structures and processes that operate within that family system. The one dimension which is most connected with such support appears to be cohesiveness. Cohesiveness is defined as the degree to which family members feel connected to and help and support each other (Solomon, et.al., 1987). In addition this dimension of support to the victim needs to be understood under other broad dimensions in healthy family functioning (e.g., expressiveness, tolerance for conflict. Identifying the family strengths and "liabilities" was important in learning about the family's ability to support the victim and to receive proper support from the intervention system.

The support families derive from services within social agencies was conceptualized using a number of dimensions. First, helping relationships include levels of client regard, empathy, congruence, unconditional caring, and willingness to be involved with the family. Second, services can be delivered to the family by providing money, advice, information, and other material assistance. Lastly, a therapeutic intervention in the family can provide assistance for emotional, behavioral, family or marital problems. The nature of the intervention will vary depending upon the relationship between the perpetrator and the victim.

Social support systems include two dimensions, (1) a personal informal network and (2) an informal social network. Generally authors and researchers have explored the role and function and needs of the family separately for cases of intrafamilial and extrafamilial child sexual abuse. It was assumed that the dynamics of support were mediated by the fact that the sexual abuse of a child was committed by an offender either inside or outside the family. That person could easily mediate the dynamics of support. The quality and delivery of service may also be mediated by the demands of the organizations who provided the services. There are a large number of outcomes that are dependent on the nature of an interorganizational network. These outcomes, as previously discussed, have effects on the victim, family, organizational and network levels. Outcomes, such as effectiveness are both simple and complex. The current assessment examined effectiveness in a simple and basically perceptual fashion, in that current assessments by administrators of ongoing inter-relationships will always influence the development and operation of future relationships between agencies.

In the case of victims and their families, both quickly become part of a very complex set of processes following disclosure. Unlike many other human services, the system's response to sexual abuse victims and their families involves a number of agencies through which intervention, legal and therapeutic responses are made to a victim. In essence, services are provided, if they are provided, to a complex problem on the basis of mandates, organizational goals, and, at times, conflicting orientations. In any case, to maximize the support to the victim and the family the service actions or responses between agencies must at least be compromising and coordinated to ensure that the supportive elements be increased and the victim is done no "new harm."

The goal of any needs assessment is not only to assess risk, service need and utilization, but also, to assess service structure needs and the degree to which organizations act in a concerted manner to achieve, if any, mutual objectives for victims and families. This initially implies that levels of coordination between agencies needed to be assessed for problems and resources that will influence the effective and beneficial delivery of services (Tessler and Goldman, 1982).

The critical importance of organizational environments has been documented frequently because of their influences on what goes on within and between service organizations. This analysis recognizes the fact that a delivery network of services to the victim of child sexual abuse and their families is greatly determined by organizations, their environments and the relationships that exist between organizations (IOR). All directly affect the delivery of services. The needs assessment examined those areas of organizations which most significantly affect the integration of services -- mandates, protocols, IOR, and awareness of child sexual abuse. Any integrated approach, a political-economic one (Benson, 1982) especially, required an examination of the requirements and resources of agencies. In addition, we must examine the needs of coordination, and monitoring of services and determine the ability of services to cross boundaries in an integrated fashion.

In the past two decades, major changes have emerged in both the size and scope of the human services provided by public and private agencies. Two problems have concurrently evolved -- the supply of resources and coordination of services due to increasing program and organizational complexity. Of central concern to the proposal was the problem of coordination. Many of the problematic aspects of services are well known -- fragmentation, discontinuity, unaccountability and inaccessibility (Piliavin, 1968). The proposed needs assessment of agencies and delivery systems necessitates both an inventory of agency resources plus the combined network of resources. Their transportability between clients and locations also require assessment. And lastly, communities, both rural and urban, differ in their dynamics of support for the victim commencing with pre-disclosure. All the aforementioned factors should not increase the probability of further victimization.

Information priorities for the needs assessment were based upon three factors; critical concerns identified in the literature on sexual abuse, factors identified in the initial data gathering, and maximum utility of needs assessment information for an intervention model. Each category of focus whether actors or processes were systematically ranked by percentage points as evidenced by Table 1.2. First, percentages reflecting priority were applied to actors and the final priorization was distributed as 25% victim, 5% offender, 15% family, 40% services and 15% community. Secondly, processes were ranked for priority. A consensus was reached on the following distribution, 25% disclosure, 10% investigation, 20% intervention, 40% therapy, and 5% prevention. Lastly, with the two sets of marginal constraints, percentage priorities had to be established within each set of categories.

The process focused our concern and resources in the needs assessment in relation to our general assumptions. There has been some reapportionment of priorities in the process but the distribution is still similar. Finally, each percentage point was accorded a percentage of the research budget and consequently our data collection strategy is constrained by each set of factors (process and actors) plus the allocated resources within each cell of the priority matrix.

TABLE 1.2

AREAS OF RESOURCE CONCENTRATION

in Child Sexual Abuse
Needs Assessment Project

	Victim	Offender	Family	Service Agency	Community	
Detection/ Disclosure	5%			10%	10% Hospital Police	25%
Investigation/ Evaluation	5%			5%		10%
Intervention	5%		10%	5%		20%
Therapy	10%	5%	5%	20%	Support	40%
Prevention					5%	5%
	25%	5%	15%	40%	15%	

I.7 SUMMARY:

The formulation process required extensive information collection and a difficult process of priorizing the resources, given an extremely complex but also not well understood social problem. In fact, one might say it is one of the more perplexing problems in modern society. An initial level of focus was required. The information collection review and initial data gathering processes assisted in the identification of the general assumptions of the needs assessment model and consequently how research resources were to be priorized; "victims receiving services which do no harm" and "provide maximum support from agencies and communities."

I.8 THE SYSTEMIC PROCESS OF CHILD SEXUAL ABUSE

One of the reasons why sexual abuse is so complex is because so many different people and agencies are involved in the problem and the intervention. During the sequence that begins with the first occurrence of abuse and then continues through all aspects of intervention, many persons and agencies "touch" the victim in ways that may range from traumatic to therapeutic. Furthermore, the entire process of the societal and service system response to sexual abuse is also very complex. It includes various aspects of disclosure, assessment and investigation, diverse forms of intervention (such as placement and court), therapy and prevention. A comprehensive response to child sexual abuse requires that five different aspects of the process be considered.

(1) Disclosure. The process that brings the victim into the social services system begins at the point of detection and disclosure. Detection may occur through the interaction of the victim with another person who is able to identify some signs and symptoms which may be reflective of sexual abuse. This process may lead the victim to disclose the circumstances of the abuse, or in the case of detection may contribute to the suspicion of abuse. As the victim moves through the process of detection, to disclosure, and possibly through the intervention and treatment system, he or she interacts with a large number of persons and agencies.Once disclosure occurs or suspected abuse is identified, a number of processes may occur. One would suspect that most detections and disclosures are made to persons who are part of the formal network system of the victim such as family, teachers, etc., even though the Bulger report does demonstrate a high level of professional (protection and treatment) reporting. This beginning point in the process is critical for victims. If the signs and symptoms of child sexual abuse are not followed up, or if disclosure is not accepted or validated, then the process leads to "no response" from the system and further fear and victimization for the victim.

(2) Investigation and Assessment. Once disclosure occurs or suspected abuse is identified, it is necessary to investigate the allegation to either "substantiate" or "not substantiate" the abuse. The agencies with the formal mandate to investigate are Child

and Family Services and Police. The process of investigation is the victim's first entrance into the formal intervention system. The experience of the victim will be affected by a number of variables including time lapse between disclosure and reporting, attitude and training of investigators, the nature of abuse (including whether it is familial or non-familial), and the age of the victim. The investigation is a very delicate process and requires a particular orientation. Issues of coordination between the two main investigative agencies, police and child welfare become very important.

(3) Intervention. If sexual abuse is substantiated through the investigation by either agency, the process moves into the intervention stage. If the police lay charges the cases will be presented/prosecuted in the court system by the crown prosecutor's office. Within Child Welfare, decisions will be made related to protection of the child. This may involve minimal involvement or a major intervention such as taking total charge of the child by bringing her into care. In extrafamilial abuse decisions will be made concerning parents' ability to protect. In these situations, advice may be offered to parents or there may be a referral to treatment. If the case is one of intrafamilial abuse, the intervention process becomes more complex.

(4) Therapy. As part of the intervention process, the child and family may be referred for treatment. This may occur at the early stages of intervention, or after some negotiations and deliberation. Not all children and/or families are referred. The decision to refer for treatment appears to be based on a number of factors related to perceived need, type of abuse and most critically, the availability of a service. Over the last few years the majority of the cases have been referred to either Community Mental Health Services or to private counselling agencies in Charlottetown. These services have not had any formalized treatment programs for child sexual abuse and are usually based on the ability of individual workers to either have the time or inclination to work with this population.

As the victim moves through the various processes from protection to treatment, there may be many professionals and agencies involved in their lives. The coordination of services appears to be paramount in the healing process of the victim. While various agencies and professionals involved are concerned about coordination, there are a number of gaps and problems.

(5) Prevention. While prevention lies outside the sequential process of the systemic response to sexual abuse, it is an essential component of any comprehensive consideration of a problem of such prevalence. Generally, prevention efforts have been directed towards enhancing children's awareness of the risk of sexual abuse by increasing their knowledge and "streetproofing" skills. But of course, the broadest efforts at prevention would look to the values and practices of the larger social system within which so much sexual abuse occurs. While we recognize the essential nature of such work, we have reluctantly concluded that it is beyond the scope of our study.

I.9 THE NEEDS ASSESSMENT: GENERAL PRINCIPLES, OBJECTIVES, AND MEANS RATIONALE FOR A NEEDS ASSESSMENT:

To develop an effective service, not only is it necessary to address a large number of questions about what is needed in the area of intervention and treatment, but we must also ask how these interventions apply to P.E.I. considering issues of current and future demand, current system capacity and capability and the realities of a basically rural delivery of services. Such issues are best addressed through an organized and thorough process such as a needs assessment. This process will allow for an intervention model that reflects the real needs and assures a higher level of effectiveness in helping victims.

In recent years, needs assessments have increasingly been required to document and justify programs to planners and administrators. Legitimizing need, then, becomes a driving objective or value premise in the design and analysis of assessment data to the extent of over-estimation in many situations. In our assessment, legitimacy was reduced in its priority and the nature of need and delivery of services were increased in their overall relevance priority to the design of the project.

Needs assessments typically try to determine public need by focusing on the individual or aggregates of individuals. This assessment has been designed to be systemic in nature. Thus, the focus was on the victims as they proceed through agencies, services and networks of services, as well as on selected dynamics of communities as they relate to intervention and therapy. Whether a need be actual or perceived has been a continuous debate amongst many. In our view, both are valid and require measurement. Most evaluators recognize a distinct difference between evaluation and needs assessment. The distinction, however, is more theoretical than methodological. In our approach, to needs assessment, we recognized that there are two steps necessary in an assessment (a) measurement and (b) judgment (Siegel, et.al., 1977). At the same time we note and do not ignore that judgment implies some processes of evaluation (Suchman, 1967). Although there are a wide variety of definitions of needs assessments, our choice is a very focused one recognizing the constraints and goal of the project -- a process which obtains the most useful information in determining the nature and level of need and obtains information on the most feasible ways of fulfilling those needs. In other words, the purpose is to help us define the appropriate size and type of intervention, as well as delivery, while making planners cognizant of the potential problems that exist in child sexual abuse intervention.

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II. METHODOLOGY:

II.1 A GENERAL APPROACH:

The general approach taken in this study reflects the systemic nature of the response to child sexual abuse and some of the problems engendered by that approach. During the sequence that begins with the first occurence of abuse and then continues through all aspects of intervention, many persons and agencies "touch" the victim in ways that may range from traumatic to therapeutic. From disclosure, through the processes of investigation, intervention, therapy and court, the child comes in contact with many different persons, often representing agencies that may have different (and potentially conflicting) mandates and philosophies, with different degrees of training in and comfort with the child sexual abuse problem. While "helping" her is a central concern of all those who come in contact with her, such therapeutic goals will frequently have to compete with the legal and investigative needs of those charged with the role of gathering evidence for purposes of child protection or criminal prosecution. Even in the most straightforward of cases, children must go through a great deal of stressful intervention after the disclosure of sexual abuse. Summit (1983) suggests that our "uncertain and variable response from whatever personal and professional resources are enlisted for help" will often " fail to protect the victim against the secondary assaults of an inconsistent intervention system" (p. 183). Thus, the response to the initial victimization of sexual abuse may produce a sense of revictimization that exacerbates its effects. Before we can begin to meet the therapeutic needs of these children, first we must be certain that we are doing no harm.

The general methodology of this study derives from both the systemic process of intervention, and its potential to revictimize as well as support victims. While the child is supposed to be at the "center" of all of this activity, it seems quite likely that her needs and her voice could be "lost" in this massive intervention process. Thus, this study is designed around several key emphases:

1. This study is centred around the experience of the children (and their families) who go through the process of intervention. In thinking about the response to victims, "Most important of all is the need to involve the victims themselves in the design and implementation of new initiatives so that they may be empowered to shape and control their own healing process (Mathews, 1989, p.3)."

2. The systemic nature of the intervention system suggests the need to examine children's experiences with all the persons involved in all aspects of intervention (i.e. disclosure, investigation, intervention, court, therapy) with particular attention directed toward identifying sources of victimization and support. It also suggests the value of learning about the perspective and experiences of workers in all phases of the

intervention system.

3. The value of perspectives, and integrative approach. It is useful to draw upon a variety of sources and different types of information in order to help us understand the child and family's intervention experiences, and to identify needs and potential solutions. Thus, information from such diverse sources as case records, psychological tests, interviews with adult survivors and systems "workers"(i.e. social workers, therapists, police, Crown prosecutors, judges, victim services personnel) case problem indexes and surveys of experiences of different "workers" in the service system and in the community (e.g. schools) will all be considered together with information from victim and family interviews in the effort to better understand victims' experiences, and to identify needs and ways of responding to them more effectively in a model of intervention.

While the particular implications of these three emphases will be developed in relation to the methods of each of the "needs areas", there are two other important methods that should be introduced here:

II.2 THE ADVISORY COMMITTEE. Child sexual abuse is a complex problem which involves many agencies and organizations. Because of this an Advisory Committee was assembled which consisted of representatives from a wide variety of agencies who either work directly or are in some way involved in the child sexual abuse problem. These included both government and non-government agencies. The primary function of this Committee was to provide advice and feedback to the members of the Research Team throughout the entire needs assessment process. The members of the Advisory Committee had a wide range of backgrounds and experiences as well as different approaches to the issues of child sexual abuse. By bringing together these people for the purposes of the Needs Assessment, it also gave them an opportunity to discuss their own approach, share their problems or simply make other Committee members more aware of what is being done in this area.

When the Advisory Committee was being formed, various agencies involved with the sexual abuse problem throughout the Province were contacted to find out if they would be interested in naming a representative to sit on this Committee. The result was a Committee consisting of representatives from Child and Family Services, RCMP and municipal police, Mental Health Services, Justice, Public Health Nursing, Medical Society, schools, as well as Transition House, Rape and Sexual Assault Crisis Centre and several other private agencies (refer to Appendix A.1 for a complete list of members).

Meetings with this Committee initially involved an exchange of ideas about the sexual abuse problem from the perspectives of the various Committee members. This gave everyone an opportunity to explain her/his perspective and allowed the members to become more familiar with each other and the work they did. Each member was asked to submit a list of the five most important elements/greatest priorities/greatest needs that she/he would like to see addressed in a model for intervention. From this list, four major elements were identified and working groups were formed based on the person's expressed interest or concern with a particular aspect of the sexual abuse problem. These four issues were (a) coordination; (b) treatment and support; (c) legal response and (d) disclosure/entry into the system. Each working group met individually to discuss ideas around each issue based on their own experience and also on literature provided by the project. The small groups reported back to the entire Committee at the regularly scheduled meetings.

Some of the key areas addressed by the coordination group included such items as within and between agency communication problems and protocols and role clarification. The treatment and support group discussed concerns about direct services, case management and community development. The legal response group had as its primary concerns the need for a child centred court process, trained personnel and up to date protocols. Barriers to disclosure, particularly within the educational, medical and social service systems were key areas discussed by the disclosure group as well as the idea of making schools "disclosure friendly".

The next stage in the Advisory Committee process was to hold a half day meeting during which the nominal group process for identifying all issues relevant to sexual abuse and then narrowing these down to a number of key issues was used. The larger Committee was broken down into three smaller groups. Each of the smaller groups consisted of at least one member from each working group that had been discussing a particular issue. The nominal group process began with each member in turn identifying a problem or concern that she would like to see addressed in a model of intervention. Once every person had exhausted her list of problems, these were priorized according to a group consensus. As a result of this process twenty-three key areas were identified. (see Appendix A.1 for a complete list). Due to time considerations, these were mailed out to the participants along with the statements comprising each heading and each person was asked to rank order them and return the list to the project. The top five were (1) treatment; (2) coordination; (3) investigation; (4) system is not child centred and (5) disclosure. (refer to Appendix A.1 for the complete rank ordered list).

The final meeting of the Advisory Committee consisted of a day long session at which members were again divided into three working groups. The purpose of this day was to devise concrete recommendations for components of a model for intervention. The groups were each given a scenario of a moderately complicated child sexual abuse case and were asked to take it through the system. At each step in the process, from disclosure, investigation, intervention, therapy and court, they were asked to make suggestions as to what they would like to see implemented that would improve the process for the children who would be going through it. Certain guidelines were given, namely to remember the rural nature of the province and problems associated with rural service delivery and also to bear in mind the cost of their suggestions. (refer to Appendix A.1 for complete list of recommendations). These have been taken into consideration during the model development process.

Throughout this project, the Advisory Committee has played a vital role. On an individual basis, Committee members were a source of information about their agency or about various aspects of the system and as a group the Committee was instrumental in advising the Research Team about problems, issues and concerns surrounding child sexual abuse. Because child sexual abuse is a complex problem involving numerous players, the Advisory Committee was central in bringing many of these players together in an atmosphere of cooperation in helping to improve the current service system and make it better for the child victims.

Prior to the submission of the model, the Advisory Committee was asked for their comments and approval of the various elements of the model. The function of the Advisory Committee is not yet completed, as it will continue to advise and provide feedback throughout the model implementation phase of the project.

II.3 COORDINATION PROBLEMS AND ISSUES

A subcommittee within the CSA Advisory Committee was created to examine the parameters and nature of coordination difficulties in child sexual abuse cases. The committee was comprised of individuals who could represent the Justice, Therapy, Social Services, Police and Support perspectives. The committee spent numerous hours in meetings and discussions, as well as doing "homework" on the many actors and components in the present "system" of response to children who have been abused. Moreover, they spent additional time canvassing their counterparts in these different perspectives.

A strategy for exploring coordination, its dimensions and problems, was devised. Committee participants were asked to look at coordination problems in a general sense. In other words, identify anything we "saw" as a problem of coordination and their connection to outcomes they felt were due to poor coordination. We later analyzed those in terms of the real components of coordination (e.g., communication, defined interdependence, roles, role clarity, goals, etc.).

In order to facilitate the "unraveling" of problems of coordination and its suspected causes, committee members used the following strategy. Issues or problems in coordination could appear or operate at several levels, for example at the worker level and the agency level. Likewise, the source or nature of the problem could be within an agency and between agencies. Therefore, the following categorization of problems was utilized.

TABLE 2.1

		Level of Problem	
		Within the Agency	Between Agencies
Source or Nature of Problem	Worker	A Work or Inter-Worker relationships within the agency	B Work or Inter-Worker relationships between agencies
	Administrative	C Internal Agency structures, processes or policy	D Inter-agency policies, structures or processes

The consensus of the group was to make its major focus category "B" - work and work relationships between agencies; and its secondary focus, internal agency factors and inter-agency factors, since other aspects of the needs assessment would deal with those more directly. Next were the work and organizations that would be focused upon. The following list was identified as sources of issues.

A. Hospitals/Medical
B. Schools
C. Police
D. Social Services (Intake and Long term), Child Protection and Other

Services
E. Prosecutor's Office
F. Probation, Parole
G. Victim Services
H. Probation/Corrections
I. Therapy Services
J. Support Services (Volunteer Agencies)

The group initially decided that their discussions would be confidential to increase the level of "frankness" and avoid "blocks" in discussions. Secondly, it was agreed that we would later decide on how much specificity in terms of particular issues between individual workers or agencies would be discussed with the Advisory Committee. The general consensus, later, was to discuss general issues and problems. Many of the issues the committee identified were later used in instruments, interviews and discussions the research group had with other agency personnel. Specific recommendations are referred to in the planning phase of the intervention model.

Although volumes could be written on the material covered and discussed, the following review and analysis will be limited to major issues and specific recommendations in the many areas that were reviewed. The specific empirical concepts related to coordination will be avoided, since the research discussion will cover them in much more detail.

A review of activities between different workers in other agencies was conducted by the group. This was completed by looking at the work and relationships between workers in ten different types of agencies which, with simple arithmetic, creates one hundred different groups of relationships - only the most significant were reviewed - approximately forty.

It is best to examine some of these problems in the context of the processes involved in a case of child sexual abuse - complaints, disclosure, investigation, intervention - charges, victim assistance, court, therapy (victim, family, offender), support, parole, probation, etc.

The first major area of importance was investigation.

Investigations are the result of complaints made to either the police in Prince Edward Island (Municipal or RCMP) or to Social Services. Each will learn of the complaint by contacting the other according to protocols previously established. The nature of those protocols, their recognition and difficulty of use were discussed in depth as a major problem to be addressed. This matter of protocols extends to other reporting agencies. Likewise, the variation in notification by type of cases and conditions was also recognized.

Investigations, when both the police and social services are jointly notified, requires a large degree of coordination between them as to timing, roles and strategy among other things. The outcome of this phase for the victim, as well as for the family, can have varying degrees of positive and negative results. The levels of specialization and experience in both agencies were seen as a problem at times. This is seen more frequently in rural areas or where there are currently heavy case loads in urban areas reducing the availability of the most experienced officers and workers. Many coordinative problems increase when the type of case, nature of complaint, offender, and turnover, among other things, are taken into account. These are dependent, as well, on administrative support, mandates, supervision, jurisdiction, access, protocol and other agency and inter-agency issues. In addition, much larger issues, such as the charter of rights, property rights and offender rights have significant influence upon the role and inter-role conflict investigators must deal with in trying to coordinate their behavior with the behavior and needs of the family.

Case loads was continually identified as an issue by not only police and social workers, but other professionals and support people. The resource components of coordination will be identified throughout this review. One major component of resources is the availability of trained investigators who are skilled and knowledgeable regarding investigations with children, victim and family dynamics in abuse cases, and the collection of evidence.

In some situations, the coordinative behavior between police and social workers is also a function of other agencies and professionals - schools, hospitals, and physicians. This may involve not only the entire process of disclosure and reporting, but also the investigation phase of getting access to children, finding or using suitable interviewing facilities, cooperation, and the collection of medical evidence among other things. In situations involving hospitals or medical personnel, it may be matter of access, timing, waiting, cooperation or sensitivity. What is significant to point out now are the levels of reciprocal action. In other words, how much does what one person does affect what another or others consequently do. The subcommittee quickly learned and recognized that from what each person does in the process of a child sexual abuse case, there are, at times, moderate to high levels of reciprocal influence between them. The outcome of this can have a mild to devastating effect upon the victim, directly and indirectly.

During the course of investigation, social workers and police must coordinate many aspects of their collection of different types of evidence and, in the case of social workers, the assessment of the victim, the family situation and evaluation of risk. Obviously, the conflict of goals can become a coordinative issue as can the flow of interviews and the use of interview aids or lack of their use. Therefore, issues connected to consultation before and during interviews, case assignment, cooperation, experience, length of investigation and turnover of investigators become directly connected to the investigation evidence outcomes, given two different general purposes - protection and charges. One of the major problems identified was the sequence and flow of effective information between investigators and investigative skills. It appears that both require a more comprehensive understanding of what each does, how they do it, and why they "must" do it in particular ways. More effective and efficient forms of investigation appeared as a major recommendation with heightened joint decision-making coupled with useful protocols which include the Prosecutor.

Police and the Prosecutor's Office have a distinct relationship in the laying of charges and the prosecution of a case in court. Informative flow was recognized as a major coordination issue, but this also involved general difficulties in role clarification and evidence requirements. Access and scheduling, due to caseloads of the Prosecutor and police, also influence coordination in the justice sense; as does specialized skill, knowledge, experience, and consistency.

In the justice system, Victim Services' staff must play a role with police, prosecutors, and social services. The coordinative aspect of the relationship may primarily involve victim preparation for court, testifying and victim impact statements. Several difficulties were identified in terms of the role clarification of each participant with the victim and the flow of information about cases, court and involvement with the victim by each participant. Accessibility and awareness of each seemed to be an issue to be addressed. Clear referral and reporting policies between all agencies with Victim Services is another. Lastly, clear and consistent expectations between each is required.

Although mental health agencies and hospitals do not have much contact with the police, they do have significant contact with social services' staff through either intake workers, long-term workers or other services. Both note a lack of clarity in roles between therapist, social worker and client. The transfer of cases within Social Services created several coordination problems for both therapists and clients. The flow of information and the nature of information at referral was seen to be problematic at times. Of particular concern was the credibility of the referral based upon assessment. Access, waiting lists and effective treatment in mental health agencies created problems for workers in both rural and urban areas. This applied to victims, family members and offenders.

The status of young offenders and the role of responsibility was seen to be both a coordinative problem and an inter-agency issue which required clarification. Expectations in treatment by other agencies was seen to create coordinative difficulties, as did the flow of information about therapeutic progress and problems. The lack of continued contact with the victim by agencies was also seen as problematic.

Issues of confidentiality among all participants from schools through both court, therapy and social services were seen to influence coordination and its outcome for victims and families. Of particular concern was the notification and preparation of expert witnesses for court testimony in cases of child sexual abuse. This could probably be a combined difference in understanding of roles, client relationships and the lack of use of expert witnesses in both mental health agencies and social services.

To all participants, the priority of cases for therapy and mandates were of particular concern because of the effects of delays on victims, families and offenders to both Justice and Social Service Agencies. In addition, the lack of equal distribution of service and access were of particular concern to the committee.

As the victim moved further from the investigation phase into the Justice and separate Services systems, the coordination difficulties seem to increase, especially in problems that are information based. For example, social workers and sometimes police felt there was insufficient information available about parole/probation outcomes, or there may have been a lack of continuity. This affects both police awareness of offenders and present/future Social Services decisions and awareness regarding risk to the victim or family.

Numerous agencies interact with volunteer agencies who provide both counselling and support services. The general consensus was that many agencies and their workers were unsure about their roles in many cases. Referrals were also seen as problematic because they may not use available resources and their dispersion may create problems of service and intervention difficulties. Lastly, there was a concern about splintering of services and the coordination difficulties when dealing with victims and their families. An increased integration of support services and their coordination with existing services was seen as a major requirement.

Of major concern was the lack of and potential development of more sharing of information and decision-making in case plans, interventions, and service use. This is directly tied to a system were caseload demands are high and the lack or delay of individual staff response to another's needs then moves each component of decision-making from the proactive to the reactive modes. Hence, certain aspects of interventions may occur which are ineffective for the victims and inefficient use of resources.

In terms of the court system, a major difficulty was seen to be court delays and the nature of court processes. Obviously, as has been mentioned before in this report, it can delay the child's healing or add more trauma - hence, more victimization. They also affect other decisions in therapy, social services and support services, and the coordinative response between those workers and the client, as well as between themselves.

In brief summary, many of the major areas defined by the Advisory Committee are components of and resources required for a more coordinated response to victims and their families. For example, training, specialization, available service, information flow, protocols, reporting requirements, assessments, and other types of resources are some of the preconditions for coordination. This is not an outcome (a goal in itself), but a process which creates better outcomes for victims and their families. If these components and others are securely in place, coordinated investigations, for example, are possible in the sense of providing more beneficial outcomes for the child, and less victimization. In this sense, the required components for more effective outcomes have to be in place. A planned, integrated and accountable intervention can occur based upon informed, skilled, independent and interdependent decision-making.

The final concern of the group was to discuss the question of how a more coordinated approach can be possible at the client/service-provider level. At this point it was recognized that coordinated behavior between a client, a service provider and between service providers was not feasible unless they had appropriate structures, processes and policies within their agencies as well as between them. In other words, coordinated behavior between service providers was not possible unless agencies were also coordinated in their approach. Agencies make the conditions under which service providers must work independently with clients and inter-dependently with each other.

Concerns at this level, both intra and inter-organizational, such as confidentiality, mandates, work specialization, service availability, referral structures, joint programming and planning, and information flow among other things are discussed in later sections of the report. The concern at this point was to focus at the service-provider or worker level. Each member of the subcommittee were "front-line" workers who had experienced when coordination had occurred and when it had not. More importantly, they knew what happened when there was none, some and a lot of coordination. They experienced the outcome and saw what the victim or family had experienced as a result of poor coordination between themselves and others. This was discussed frequently in the group.

The major concern for the group was "how do you get around or eliminate all these problems and create a much more coordinated response to victims and their families?" The answer was quite simple - coordinate the work and behavior of staff within agencies and between agencies. The solution was much more difficult to identify and test. In fact, the group raised many more questions, but also pointed to more and more appropriate solutions.

In brief, the subcommittee realized that there had to be a planned approach to all the aspects of interventions, services and service delivery. This included everything from reporting through investigations, courts, services, therapy, and support. The only way one could identify if gaps occurred, services were not being provided, services were not effectively delivered, made available, matched with need and so on was to have someone coordinate the services, behaviors of the service-providers, and intervenors. Their behaviors, however, had to be 'coordinateable' and the interventions and services had to be 'coordinateable'.

Other concerns were - how would one know if the coordinated effort was not working or part of the effort was not working because the only person who would really experience the outcome would be the victim and the family. So, somehow the progress of the case had to be monitored along with the affects on the victim. Likewise, if people had to coordinate their behavior, they would require information about the victim, the victim's progress and the victim's situation. Someone, therefore, would have to collect this information and make it accessible to others, enabling them to adjust their work and interaction with the victim and their family accordingly, and to be capable of planning and integrating their intervention and services. But what occurred when parts of the coordinated effort did not work or did not respond in a timely or effective manner with the victim? What happened when services were not available or workers and agencies were not cooperative? In other words, could you or would you try and "force" some outcomes for the benefit of the victim? These were seen as some of the requirements at this point in time to address many of these issues.

The group recognized that not all cases were the same. Some were relatively straightforward, others were slightly problematic for everyone. The difficulty here was how does one plan and try to integrate these interventions and services? More importantly, was the question of who should do this given these varying conditions in both the victim's life, the family, and the service providers. Whomever did it must monitor it and correct it. This required not only a level of working cooperation, but integrated behaviors on the part of the intervenors and service-providers. In other words, a lot of pre-conditions had to be in place and working.

The last major area of concern was decision-making. Obviously, in cases of child sexual abuse there are conservatively speaking, thousands of decisions to be made from the reporting of the abuse through the long process of interventions and services to the closing of the case and the remaining monitoring of the client, their family, and the offender. Again, the question was who should do it. What decisions should be made by independent workers making those decisions together. In other words, they assessed together, they planned together, and evaluated their coordinated efforts together, even though they were in separate agencies with separate mandates and requirements. Would things work better for the victim if all this separate and specialized information was brought together and intervenors and service-providers would jointly decide how the case would be planned and modified given changing conditions for the victim and the family? It seems that people's goals would be clearer. They would realize that their behaviors were very interdependent, indeed, they had to be, and they sure would know each other's job with a victim in a more clear and compassionate manner. It appeared in the sociological sense that people could integrate and coordinate their actions much more effectively when "they could occasionally wear each other's shoes."

At this point in time, the solution to many of these coordinative difficulties and issues could be solved or at least remedied, if someone coordinated these cases with others who were responding to victims and each other, intervenors and service providers would jointly decide the nature of the response-intervention and services. The feeling amongst group members was that some coordination is evident in some of the cases. In other words, people work things out informally in terms of their work with clients. The concern, however, was what happens when things don't work out? What happens when one of those cooperative people leaves or gets transferred? What happens in rural areas? What happens when agencies do not cooperate, people don't cooperate, or have too heavy of a caseload to communicate, among other things? In other words, can we assure victims that they will get equal quality and a coordinated response no matter how hurt they are, who they are, or where they happen to live? What seemed to be required was not only a coordinated effort and response to victims and their families, but it had to be formalized and available to everyone in need.

The nature of this response to meet the need of a coordinated response is treated in more depth in later sections and the "model" of intervention and services.

II.4 SPECIAL NEEDS GROUPS:

Child sexual abuse affects children of all ages and from a variety of backgrounds. It may also affect children who are disabled, either mentally or physically, children who are in foster care or day care, Native children and children who are members of various volunteer organizations. Children in all of these areas have special needs and some are more vulnerable than others to this particular form of abuse. A study on the needs of sexually abused children and their families would not be complete unless the needs of these children were taken into consideration.

It is a complicated process to access children in these areas and in many cases, it would not be appropriate or even feasible to talk directly with them. In order to try and obtain some information about these "special needs" groups, a day long forum was planned which would allow representatives from these various groups or agencies to speak with the research team and tell them about their concerns in this area of child sexual abuse. Letters of invitation were sent to all of the above named organizations informing them about the nature of the research and asking them to participate in a forum. It was the original intention to have a presentation of briefs and to schedule times for these to be presented. In addition, there was to have been both an open and a closed session for those who would prefer to discuss their issues without an audience. However, the response to the invitation was disappointingly small so the intention of formal brief presented was discarded in favour of a "round table" discussion which would be considerably less structured and would require those attending to spend less time in preparation. The length of the session was reduced from a full day to a morning. There were five participants and they were from the day care sector and the early childhood education as well as a former child welfare worker. A separate session was held to discuss concerns about sexual abuse of children while in foster care.

The Native population has a special concern with the child sexual abuse problem and representatives from the Native Council were asked to sit on the Advisory Committee as well as attend this forum. They chose not to do either and perhaps this is a reflection on the fact that their needs in dealing with sexual abuse are quite distinct from those of other victims. Their paths to recovery must follow Native ways and culture and as such cannot be dealt with adequately in this research project but ought well to be a project devoted to nothing but Native issues.

The issues and concerns that were raised during the half day meeting are as follows:

a).**problems with accessing resources**: Many people do not seem to be aware of what resources that are available to assist sexual abuse victims and their families and finding out about them appears to be, for some, a matter of chance. One person recounted the difficulty a family had in trying to find therapy for their child. After they had been "bounced around the system" for about 3 years, they were still not able to find out where to get help simply because they did not know what questions to ask nor whom to direct them. He approached Social Services on behalf of the family and was able to get the child to see a counsellor because he was able to find out the correct route to take. Guidance for the children and their families is needed in order to maximize their ability to access the proper resources that they may need.

b).**the process is not child centred**: While this has been heard from different sources throughout the course of this project, it is important to mention it here as well. There was a general consensus that there were too many people asking too many questions and few who were able to establish a relationship with the child. There is no one person who can take the child and the family through the whole process and whom they can trust to help them to cope with what is happening. Therapy can also involve too many people as it sometimes happens that the child is seen at one agency while the family is at another. It was suggested that there should be therapy for the whole family available from one person, or at least at the same agency.

The court process was mentioned in this context and it was again emphasized that it is far too concerned with the rights of the offender and not enough concerned with the needs of the victim. The focus is on prosecuting the "criminal" and not on helping the victim. One suggestion was that court should be closed and confidential for sexual abuse cases.

c).**feedback and support to those reporting the abuse**: Several issues were raised in this general area. First of all, people may be afraid or unwilling to report suspected cases of sexual abuse for fear that their names will become known. Prince Edward Island is a small place made of even smaller communities and many things quickly become common knowledge. Although confidentiality is assured by law for those reporting child sexual abuse cases, the reality may not always reflect this. A story was told about a person who reported a suspected case to Social Services and the social worker went to the parents of the alleged victim and told them who had lodged the complaint. The parents went back to the person who had done the reporting and were very upset with her. She felt that the social worker had released information that ought to have been completely confidential and in her experience this had happened previously. The same person was aware that the social worker was freely giving away information in several other cases where she had no right to do so and yet the community was small and the complainant was hesitant to do anything more about the actions of the social worker.

The second issue dealt with lack of feedback. Once a person lodges a complaint of sexual abuse, it is not common for them to know what happens to the child. It is important that those who care enough to report an abuse be given some information, with all due regard to the privacy of the victim and family. The reporters need to "see that what they've done is justified in the end." It would not be necessary to provide detailed information to the informants, but rather make them aware that the child is safe and that appropriate actions are being taken.

d.need safe ways for children to report abuse: This is particularly true for those children who are abused while they are in foster care. The actual numbers for this type of abuse are not known but it does happen and steps must be taken to quickly protect the child when it does. When a child is in foster care, it is because she is coming from an intolerable home situation and the foster home is intended to be a place of safety for her. If sexual abuse occurs within this context, the child has been put in an even more dangerous situation because her protectors have now become her abusers and where can she turn for help? If there is no relationship based on trust between the child and the social worker, then the child is very much left alone and afraid with nowhere to turn. A safe way for a child to report sexual abuse is needed and the most available one could be through her social worker if the social worker was making frequent contact with the child and was able to establish a trusting relationship with her.

Reports of abuse in foster care came out in two of the interviews with adult survivors and one young woman, who was attending a Youth Forum, reported being abused while a foster child. One therapist felt that there had been some problems in the past, but was unaware of any current problem. This type of abuse does happen but the extent and nature of the problem is not known and could be a study on its own.

e.more education about sexual abuse: One of the people attending the forum raised the issue of prevention and the way children are viewed by our society. He felt that it was time to challenge the way adult view children and the way our attitudes perpetuate the cycle of sexual abuse. There is a need to educate, both adults and children, about the problem of sexual abuse and what can be done about it. Society must make the sexual abuse of children totally unacceptable and the first step to doing this is education.

This is by no means intended to be a comprehensive report of the needs of some of the special populations of children mentioned here. Obviously, there is a more detailed information about the special needs population which could be obtained if time and resources permitted. This could be the focus of a smaller needs assessment directed strictly at these groups. Some of the people who were unable to speak would no doubt have a great deal to offer about their groups, most notably the Native Council, the physically and mentally handicapped and foster children.

This forum was designed to bring together representatives of various groups and encourage them to begin exploring their needs concerning the sexual abuse problem. Unfortunately the results were not exactly as would have been hoped for but the information given by those who attended was certainly heard but more research into this area is needed if anything meaningful is to be done to help children who belong to any of these groups.

II. 5 INSTRUMENTS[1]

Information was collected from a variety of sources and was obtained either from an interview or a questionnaire. Information about victims and families was collected directly from the victims and families but was also obtained from the perspective of therapists, social workers, and guidance counsellors. Information about the needs of the service delivery system was collected from therapists, social workers, police, Justice and probation. Interviews were conducted with victims, families and adult survivors as well as with a sample of therapists, police, Crown prosecutors and social workers. (Refer to Table 2.1).

Information on victims came first of all from the child victims but also from adult survivors of child sexual abuse. It was felt that these two groups could offer perspectives on the needs of victims from different points in time - the children from a quite recent time period while the adult survivors would be able to talk about their experience from a vantage point somewhat removed from what is currently available. Families of victims were also interviewed, both about the needs of families when going through the process from disclosure to court and then the sometimes quite long recovery period but also about the experiences that their children had in intervention and about the needs of victims.

1. VICTIMS:

Information was collected about victims from the following instruments. Some of the instruments have overlap in that they ask questions about the victims, the families, and the offenders. Each major heading (i.e. VICTIMS, FAMILIES, and so on) will include a list of the instruments which gather data about them. If the instrument has been described previously, reference will be made to the section in which the detailed description occurs.

A. Interview Guide for Children:

The questions asked during the children's interviews did not concern the abuse experiences themselves. Rather, the focus was on the experiences and perceptions of the child as she went through the various steps in the intervention process, beginning with (a) disclosure, and followed by (b) investigation, (c) intervention (Social Services), (d) therapy and (e) court. Children were asked about the response of others to them during this time (workers, family members, friends) and about their feelings and reaction to different aspects of intervention. They were asked to identify what was most helpful to them and most difficult for them during the different phases of intervention and for their entire experience overall. Their recommendations for what would be most helpful for other children going through intervention were also obtained.

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[1] The complete instruments are in Appendix B.

B. Interview Guide for Adult Survivors:

The interview with adult survivors was more of a complete narration of the impacts of abuse on their lives and their processes of recovery. The interview asked about the survivor's (a) background and family, (b) experiences of abuse and their feelings as children, (c) process of disclosure (and any intervention experience they had if their abuse was reported when they were children), (d) the effects of sexual abuse on their lives and (e) their experiences with recovery from their abuse. Survivors were asked to indicate the most helpful and harmful aspects of their own experiences and were also asked about what they felt children needed at different stages of the intervention process in their roles as "key informants".

C. Interview Guide for Families:

In addition to being asked about their own experiences, parents also were informants about their children's experiences in the intervention system (e.g. describing children's reactions, identifying sources of support and difficulty for their children, etc). (See the FAMILY section for further detail).

D. Information on Children in Therapy:

The perception of therapists about victims was obtained by means of an Information on Children in Therapy questionnaire distributed to all therapists who treat children who have been sexually abused. The therapists were asked to complete one questionnaire for each sexual abuse case they had been involved with during the past two years. The questionnaire asked the therapists to rate the degree of seriousness of the abuse and the impact of the abuse on the child. They were asked about the adjustment of the child and the support of family and friends. Information about the type of therapy, relationships between the child and the therapist and the therapists' rating about the level of upset and the effects of the various intervention decisions that may have been made were also obtained.

E. T2 - Information on Cases Currently in the System:

Since the first contact many victims have with the system is with Social Services, several questionnaires were sent to Social Services. The workers were asked to complete these on all active cases that had been on their caseload during the year and on each new case of sexual abuse that came in during the time of the project. Three different questionnaires were sent to the workers collecting three different types of information. The first, T2-Information on Cases Currently in the System, was designed to find out about the reactions and support of the family to the victim both at the time of disclosure and at the time the questions were being answered. Questions about family structure and demographics were asked as were questions about the ability of the family to respond to the child's needs and to protect her from further abuse. Sources of support available to the victim and the service needs of the family including such services as financial support, housing, legal services and so on. The relationships of the worker with both the victim and her family were examined. There were questions designed to find out more about the time spent by social workers on sexual abuse cases and the result of the investigation with regards to issues of verification and complaint evidence. The final section of this questionnaire asked about family functioning based on scores on the Family Health Scale. This is discussed in detail in the section on families.

F. Data Schedule:

Social workers completed Data Schedules on current cases. Data Schedules were also completed from the records of Social Services on cases that had been closed. Social workers did not fill in the information from records - a person was hired by the project and approved by Social Services to do this work. Throughout this report, wherever information from past cases is mentioned, it was collected from the Data Schedule. This instrument was formulated to collect data on the abuse including such areas as when and where the abuse took place, how long it lasted, the type of abuse and whether or not coercion was involved. Information on the victim (i.e. age, sex, other victims), the family (i.e. type, marital relationship, socioeconomic factors, problems) and the offender (i.e. age, sex, relationship to the victim, problems) was collected. The path the complaint took from the time the case entered the system and the point of formal disclosure was drawn. Case contacts (providing or getting information on the victim and family) and case referrals for service were itemized as well as the decisions made regarding intervention (i.e. victim removed from the home, offender removed from the home, case sent to court). The final section of this questionnaire was a Service Utilization Index which outlined the utilization of services within Social Services and whether or not these were being used before or after the case was validated and the length of time each service was used.

G. Case Problems Index:

The final instrument completed by social workers was the Case Problems Index. This gave a very detailed examination of the areas of problems that workers might encounter while investigating a case of child sexual abuse. More specifically, it asked workers to identify areas in which there were problems (i.e. with the victim, with the police, with therapy). Within each major problem category there were sub-categories specific to that area. For example, age related difficulties and victim cooperation with the investigation were sub-categories of the problems with victim category. Workers were asked to rate the level of problem each one presented, either small, moderate or large.

They were then asked to rank order the top three problem areas for the victim and to estimate the percentage that each one contributed to the overall problems encountered in investigating the case.

H. Survey of School Guidance Counsellors:

A survey was mailed to all guidance counsellors across the Province to find out more about their role in the sexual abuse problem. Demographics were collected and information was requested about their training experiences including the focus, format, length and a rating of the value of each one to their work. Counsellors were asked about the number of disclosures they had received and the procedures each school or school unit had for dealing with a disclosure. Each guidance counsellor was asked to give a rating on her/his perception of how teachers, administrators and other counsellors functioned in several key areas (i.e. recognition and acknowledgement of sexual abuse as a serious problem, approachability and openness to disclosure). A rating of the atmosphere in the school to disclosure and how public the sexual abuse became were also elicited. Questions were asked about reporting procedures, delays, referrals and communications with therapists and social workers and existing prevention/education programs. Guidance counsellors were asked how they perceived their role in the sexual abuse problems and to make recommendations for change or improvements if they felt these were warranted.

2. FAMILIES;

A. Interview Guide for Families:

Families were interviewed using the Interview Guide for Families. During the interview, questions were asked about family composition and relationships both before and after disclosure occurred. Because the family can be one of the primary sources of support to the child, questions were asked concerning the support available to family members to help them be able to support the child throughout the process. The family was asked about its reactions at the various stages of the investigative process including Social Services, the police and overall investigation procedures. The family was also asked to make recommendations for changing the system's response wherever it was felt that changes were necessary. Questions were asked about the intervention decisions made for the family and the degree of involvement the family had in making these decisions. Ratings of the response of the social workers to the family during the time of intervention were obtained. Each stage of the intervention process was discussed separately (i.e. court, therapy for the victim, the family, the perpetrator) and questions were asked about relationships and response of the people involved at each of these stages. The final section dealt with the level of help received from various people with whom the family might have had contact. A rating of helpfulness to both the family and the victim ranging from "really helped" to "made things worse" was obtained on a number of different people such as friends, co-workers, social workers, therapists, police and so forth. (Please refer to the interview guide in Appendix B for a complete list of people).

B. T2-Information on Cases Currently in the System:

Please refer to the description of this instrument under the heading of VICTIMS above. While it is described in the section on victims, much of the information it collects is also about families and their reactions and support.

C. Data Schedule:

A detailed description of this instrument is given under the heading of VICTIMS above.

D. Case Problems Index:

Please refer to the description of this instrument above. There are several sections of this instrument which are specific to the family. The first section entitled, appropriately The Family, asks workers to indicate problems with such things as obtaining access to the child or lack of family cooperation with the investigation. The second section which deals with family problems is Social Services and the Family which asks about problems with obtaining services for the family. The third section, Therapy for the Family, asks social workers to rate the problems in accessing therapy services for the family and about the availability, quality, delays and so forth in obtaining these services.

3. OFFENDERS:

A. Sex Offender Survey:

While the focus of this needs assessment is on victims and families, some information was gathered about offenders. A Sex Offender Survey was given to probation officers across the province and they were asked to complete it on sex offenders that they had on their caseload. Questions were asked about the demographics and previous history of the offenders as well as information about the victim and about the nature of the abuse. Information about charges laid and treatment received for sex offenses both currently and in the past was collected.

B. Sex Offender Program Survey:

A mail out survey was sent to sex offender programs across Canada asking for their perspective on sentencing issues and training issues, primarily for Crown prosecutors and judges. Respondents were asked for their recommendations for the management and treatment of sex offenders and were asked about their particular program problems and strategies. Questions were asked about coordination, treatment and outcome issues.

4. KEY INFORMANTS ABOUT THE SERVICE SYSTEM:

All of the instruments discussed above were designed to find out information about the victim, family and offender. There were also a number of instruments constructed to gather information on the needs of the service system.

A. Interview Schedule for Therapists:

A sample of therapists was interviewed using the Interview Schedule for Therapists. In the interview, therapists were asked to describe their work including their personal approach to child sexual abuse therapy. Questions were asked about their understanding of and attitudes toward the sexual abuse problem and about their experiences in therapy including such things as goals, relationships and experiences with families. Issues in treating victims, families, offenders and adult survivors were discussed as well as problems with each of these types of cases. Their perspective on the therapy system was obtained on several dimensions including referral patterns, legal issues and the major strengths and weaknesses of the system. Therapists were asked questions as key informants about other agencies involved in child sexual abuse including the police, Social Services, Justice and several private agencies. Recommendations and suggestions about the needed changes in the intervention system were requested as well as some personal needs and issues each therapist might have in doing sexual abuse work.

B. Survey of Therapists and Counsellors:

This was a mail out survey which asked about both formal and informal training experiences, caseloads, type of work the therapist did and the type of treatment most frequently given. Therapists were also asked about their own level of knowledge about sexual abuse, the level of interest they had in working with these cases and their own personal training needs. They were asked to itemize the factors that affected their involvement in sexual abuse cases and what would help them to become more involved with these types of cases. Their ideas and suggestions for improving training in sexual abuse were requested.

C. Case Worker Instrument:

A questionnaire was distributed to social workers in each of the regions of the province. It was designed to gather a variety of information about sexual abuse cases. The main thrust of the questionnaire was to find out the social workers perspective on child sexual abuse cases not only as it pertained to the agency related issues but also to personal issues such as safety, job satisfaction and attitudes toward child sexual abuse. Agency related topics revolved around such things as protocols, work load, procedures, training, accountability and experience with police. In addition, questions were asked about experience, training and skills. Other information included general information on victims, risk levels, young offenders as well as problems encountered such as changes in case plan and case conflicts. Social workers were asked for estimates of the time they spend in various aspects of investigating a case of child sexual abuse and about issues in coordination with other agencies. They were asked to rate the degree of influence they had in the decisions made regarding the cases and about the decisions themselves. This was a very detailed instrument which collected a great deal of information from social workers about almost every aspect of the work they do in child sexual abuse cases.

D. Agency Instrument:

Service Agencies in Prince Edward Island were surveyed primarily for the planning and development purposes of an inter-agency model of intervention. The data was primarily concerned with the level of barriers to overcome in a "systemic" model of intervention. Additional data was collected on levels of transaction processes, dimensions of autonomy and levels of interagency arrangements and objectives. The remaining focus included resource flexibility, budgeting, and the periodicity of demand for service.

Some of the major barriers which had been previously identified were focused on in more depth. They included levels of mandate restrictiveness, joint-programming and planning experience, and the direction and intensity of communication flows. Interorganizational constraints between agencies such as operating philosophies, client responsibility and sources of caseload were examined.

Interagency development and planning are based upon a number of significant intra- and interorganizational variables. What appeared to be the most problematic were selected to measure for intensity - goal awareness, contact frequency, conflict, both goal and domain consensus, goal compatibility and perceived effectiveness. The nature of these variables will significantly influence implementation options especially when resource levels are low.

Levels of interagency contact within the Province are low based on comparative standards. Therefore, the nature of contact was examined between the thirteen agencies for levels of formalized contact, board and committee contact, binding decision-making and contact routineness.

Referrals are a major means of contact between these agencies. Our initial observations recognized a high degree of centrality in distribution. Consequently measurements were included to devise different model options for an inter-agency system of intervention.

Upon completion of the instrument, interviews review the responses in the instrument and explore difficulties in contract for service options, difficulties in the familiarity of interorganizational agreements, options for new models of interagency dependence, joint-planning options and "uncooperative" referrals among other things.

E. Law Enforcement Instrument:

This instrument was sent to each municipal police department and RCMP Detachment across the province. Questions were asked about the background information for each officer and about the experience each had with child sexual abuse cases. Questions were asked about training including training already received and training each would like to receive. Officers were asked to rate their level of comfort in doing child sexual abuse investigations and to rate their level of knowledge and skill in this area. Information was collected about protocols and procedures and problems which may have been encountered with either of these. Police officers were asked their opinions about Social Services including the role of social workers and their understanding of criminal investigations. A rating of social workers' skills, cooperation and communication with the police was also asked. Officers were asked to list any problems or difficulties they had experienced with the Crown prosecutor's office and the final part of the questionnaire asked them to list the four most frustrating aspects of doing an investigation into a case of child sexual abuse.

F. Justice Survey:

A questionnaire was mailed out to judges, Crown prosecutors and Victim Services in order to find out about the Justice system's perspective on the issue of child sexual abuse. Questions about knowledge, skills and training were asked. A list of potential problem areas was given and the respondents were asked to rate how much of a problem they felt each on to be. These included issues such as time, delays, preparation of the child for court, sentencing, court processes and so forth. (Refer to the complete questionnaire in the appendix). Respondents were asked for their suggestions on how to address what each considered to be a major problem with the court and how each problem could be addressed. Some suggestions for changes were given and respondents were asked to rate how much they agreed or disagreed with each one. The final question asked them to make any recommendations for making the court procedures better for the victims of child sexual abuse.

Each of the above questionnaires or interview schedules was designed to collect specific information about different aspects of the sexual abuse problem from a variety of perspectives. Each asks about situations or issues that are unique to the population being surveyed and thus a relatively comprehensive picture is obtained of the experience that victims have with the service system on Prince Edward Island.

TABLE 2.2

SOURCE OF DATA	DATA ABOUT	INSTRUMENT	INTERVIEW
Victims	Victims	Interview Guide for Children	*
Adult Survivors	Victims	Interview Guide for Adult Survivors	*
Therapists	Victims	Information on Children in Therapy	
Social Workers	Victims	1. T2-Information on Cases Currently in the System 2. Data Schedule - current cases 3. Data Schedule - records	
Guidance Counsellors	1. Victims 2. Schools 3. Other agencies	Survey of School Counsellors	
Families	1. Families 2. Victims	Interview Guide for Families	*
Social Workers	Families	1. T2-Information on Cases Currently in the System 2. Data Schedule - current cases 3. Data Schedule - records	
Therapists	1. Therapists 2. Other agencies	1. Survey of Therapists and Counsellors 2. Interview Schedule for Therapists	*
Social Workers	1. Social workers 2. Other agencies	Case Workers Instrument	*
Police	1. Police 2. Other agencies	Law Enforcement Instrument	
Justice	Justice	1. Justice Survey	*
Probation Officers	Offenders	Sex Offender Survey	
Sex Offender Programs	1. Offenders 2. Programs	Sex Offender Program Survey	
Agency Directors	Service Agencies	Agency Instrument	*

* indicates an interview was conducted with a sample of this population.

III CHILD SEXUAL ABUSE IN PRINCE EDWARD ISLAND

III.1 PROFILE OF CHILD SEXUAL ABUSE

The past cases selected for the analysis were based upon child protection files in the Department of Health and Social Services. Cases which had been opened during the period of 1986 to 1989 and contained validated child sexual abuse were analyzed for the study. Of the 212 case records that were reviewed, 79 cases were analyzed. Only validated cases will be discussed in this section.

In the cases that were examined, 85% were females and 15% were males. This did not seem to vary significantly over the four years. Their ages ranged from one year of age to twenty years of age. The single case of a twenty year old was based upon a delayed charge of abuse. The average age of the victims was about 10 years with a standard deviation of about 4 years. In terms of an age distribution, 15% of the cases were children under 4, 35% were between 5 to 10 years of age, 20% were between 11 and 13 years of age, and the remaining 30% were between 14 to 17, with the one case of a twenty year old.

Nearly half the cases involved another victim who had been sexually abused (46%). Of those additional victims, 50% were a sibling, 10% were peers, 15% were relations, and 24% had no relationship to the reported victim. Typically, the multiple victims involved one or two other children. One case, however, involved 14 other victims. If the case was intra-familial, 14% of the time the second victim was outside of the family. If it was extra-familial, 35% of the second victims was from another family.

If the additional victims were females, half the cases involved another female, 22% two or three females, and one case of 12 additional female victims. If there were additional male victims, 60% involved one or two additional males, most of the time only one male.

Thirty-five (35%) percent of offenders were under seventeen years of age. Thirty-six percent were between twenty and forty years of age. The remaining twenty-nine percent were between forty-one and seventy-four. The average age was thirty with a standard deviation of 18 years.

The relationship of the victim to the offender indicated that in 47% of the cases the offender was in the family. Of that 47%, 33% were parents - both biological and step-parents and 14% were siblings. In terms of the remaining offenders, other relatives (grandparents, uncles and cousins) were identified in 24% of the cases, and 30% were neighbors, baby sitters, and people in positions of trust. Ninety-seven (97%) of the offenders were males.

The validated cases over those selected years involved victims whose residences were in all three counties (27% in Prince County, 45% in Queens County, and 25% in Kings County). By census definition, 28% were in urban areas and the remaining 62% were in rural areas. The abuse itself took place in a locational distribution similar to residence. Slightly more, however, had occurred in urban areas, namely Charlottetown. In 4% of the cases, the abuse occurred outside of the Province.

The number of abuse incidents varied widely from one incident (2 cases) to multiple incidents of a hundred or more (15 cases). Approximately 35% of the cases involved five or less incidents and about 25% of the cases involved twenty-five or more incidents. In total, 70% of the cases involved multiple incidents of sexual abuse.

Age of the victim at the first incident of abuse ranged widely. The average age was 7.5 years with a standard deviation of 3.5 years. The distribution of age indicated that nearly 30% of the victims were under five years of age when the abuse began. Forty percent (40%) of the victims were between six and ten years of age. For females, age at first abuse tended to be between six and twelve years of age. For males, the tendency was toward the age group between three and seven.

If age and sex of victims are jointly examined, several patterns emerge. If the child was under five years of age, 40% were males and 15% were females. However, between ages six to ten, more than one-third were females and fewer than one-quarter were males. The majority of the female victims were between the ages of eleven and fifteen (46%). Fewer than one-third of the males were in this age group.

In general, the abuse took place in the victim's home (75%), 18% occurred in the offender's home, and the remainder (7%) took place in a car or public place. When examined in more depth, 92% of the incidents of abuse took place in both places, victim's and offender's homes.

III.1a NATURE OF THE SEXUAL ABUSE

One-third (33%) of the female and male victims had anal or vaginal intercourse. Approximately 35% of the males had been involved in oral-genital contact and 14% of the females had been involved in the same form of abuse. Nearly half (49.9%) of the females had been involved in some form of fondling. Only 16% of the males were subjected to this form of abuse.

Abuse, however, did not occur in a single form. Sixty-five percent (65%) of the cases involved both intercourse and oral-genital contact. If oral-genital contact was a main source of abuse, 67% of those cases were associated with fondling. If fondling was a main source of abuse, it was associated with exposure 52% of the time. Upon closer analysis, no distinctive pattern appeared when intra-familial and extra-familial cases were compared.

In intra-familial cases, the majority of the abuse was fondling (47%), followed by intercourse in 37% of the cases. In extra-familial cases involving females, 50% were incidents primarily of fondling and intercourse 28%, followed by oral-genital contact (18%). For males, 40% was intercourse, and 20% each for the other form of abuse.

Age seemed to influence the nature of the abuse. In extra-familial cases, 74% of the children under six years of age were involved in oral-genital contact, much less in intra-familial. In intra-familial cases, almost every case involved fondling of some form when the child was between eleven and fifteen years of age.

The form of the abuse indicated several patterns. In terms of anal or vaginal intercourse, the victims tended to be older. Fifty percent (50%) were between twelve and fifteen years of age. Twenty-five percent (25%) were younger than ten. Fondling was much more prevalent over the age of ten (70%).

Approximately seventy percent (70%) of the cases of abuse had violence or coercion associated with them. Forty percent (40%) of those cases involved physical manipulation, and fifteen percent (15%) involved some form of physical or verbal threat. Nearly half the cases had some combination of coercion or violence. This same distribution appeared across the different age groups. Violence and coercion were slightly more associated with female victims (74%) and less with males (64%).

When the type of abuse is examined in conjunction with violence and coercion, several associations appear. Physical manipulation and verbal threats were associated with oral-genital contact (42%). Intercourse, anal or vaginal, was most associated with physical threats (22%) or verbal and physical manipulation (22%). Fondling was most associated with physical manipulation (59%).

III.1b FAMILIES OF VICTIMS

Record and Data Schedules produced simple data on marital conditions in the homes of victims. About forty percent (40%) were considered unstable homes. About twenty percent (20%) had indications of past abuse of the spouse and twenty-seven percent (27%) had some indication of previous child abuse.

Only 52% of the fathers were currently employed. Thirty-four percent (34%) of the mothers were employed. Seventeen percent (17%) of mothers and 30% of fathers had histories of substance abuse. Substance abuse was more highly associated with offenders. The victims had previous problems (e.g., emotional, behavioral, etc.) of a varied nature in 47% of the cases. Families had indicated previous problems in 65% of the cases.

In terms of victims, fifty-three percent (53%) indicated no problems of a behavioral, emotional, physical or academic nature. Twenty-two percent (22%)

indicated one or two and 26% indicated three or more of these difficulties. The dominant types were behavioral and emotional.

Families, on the other hand, indicated a wide range of problems. As mentioned previously - substance abuse, marital conflict, history of abuse, employment instability, emotional or psychological problems, financial problems, social isolation or child-parent difficulties. The majority of families had between one and six problems. Almost 20% had six or more problems. Eighteen percent (18%) had one or two, and 23% had three to five problems.

Of the six problems coded, substance abuse and emotional and financial problems appeared very frequently. Marital conflict, emotional and employment problems appeared frequently. A moderate number as indicated showed past abuse difficulties.

When family and victim problems are examined in an intra and extra-familial context, different patterns emerge. In intra-familial cases, 35% of the victims indicate no problems. Sixty-nine percent (69%) of the extra-familial cases indicated no problems. Thirty-two percent (32%) of the intra-familial cases indicate one or two problems, and 12% of the extra-familial. However, 35% of the intra-familial cases indicate three to four difficulties and 28% of the extra-familial - indicating number of difficulties the victim has is not purely associated with incest, especially in terms of level of difficulties.

In terms of families, 21% of the intra-familial cases indicated no problems and 46% of the extra-familial indicated no problems. Victims, despite the source of the abuse, can come from problematic homes. Twenty-eight percent (28%) of the intra-familial cases had between one and three problems - 22% of the extra-familial cases. Forty-six percent (46%) of the intra-familial cases had four or more problems - 27% of the extra-familial cases.

Age of victim and total problems of the family do not seem associated in either intra-familial or extra-familial cases. Violence and coercion also do not appear to be associated. If marital conflict was present, the abuse tended to appear between the ages of five to twelve. When not present, age at first abuse was fairly consistent across all age groups.

If the family indicates no problems, age at first abuse is evenly distributed among age groups. As family problems increase, however, sexual abuse of the child begins to concentrate among children who are under six to eight years of age.

To further examine this. If the case was intra-familial, the age of first abuse incident concentrated around ages five to ten. In extra-familial cases, no discernible pattern appeared. If there were no problems and intra-familial, the age concentration was between eleven to fifteen.

Each case was reviewed for the nature of the complaint, who made them and how many persons or steps were involved. Most cases involved six or less, 61%. Nearly 40% involved seven to eleven steps. The average was six steps.

Disclosure, however, could occur anywhere along the complaint path. In 70% of the cases, it was in the second step. For 30% of the cases, it was between the third to the ninth step in the complaint path.

Disclosures were made to a wide variety of people. Most common were mothers (23%), fathers-parents (9%), counsellors (10%) and social workers (30%). In 82% of the cases, someone in the family was supportive to the victim at disclosure. The nature and level will not be discussed at this point.

When disclosure is examined more closely, complaint paths are much longer for intra-familial cases - 75% over six steps, especially when the victim is under eight years of age. Disclosure occurs earlier for females in extra-familial cases than intra-familial. Males, however, tend to disclose later in intra-familial cases.

Interestingly, some of the longest paths and later steps of disclosure, as well as the shortest, appear when the complaints are from mothers or disclosures are made to them. Similar patterns appear with counsellors.

In extra-familial cases, there appears to be a tendency for more young male offenders to appear. In intra-familial cases, however, the distribution of age for offenders is fairly evenly distributed between fourteen and fifty-two years of age.

Charges were laid in 47% of the cases of child sexual abuse. They were laid in 48% of the cases involving females and 42% of those involving males. Case records could not identify if charges had been laid in 20% of the overall cases. The tendency was that charges not to be laid in cases involving children under eight years of age.

For females, charges were laid in 31% of the extra-familial cases and 63% of the intra-familial cases. In addition, there was a tendency for no charges to be laid involving children under nine to ten years of age in extra-familial cases.

III.1c VALIDATION OF COMPLAINTS

A better understanding of why complaints are not validated was obtained by the examination of the details in sixty-five case records in one regional center. The cases were drawn from our past and present data sets. A supervisor examined the records, and completed a sample form and provided additional details.

The reasons why a case of child sexual abuse are not validated vary significantly. No single reason determined the lack of validation of a complaint. It typically involves several combinations of reasons.

The most significant combination is that the complaint was based upon a "hearsay" allegation - the worker suspected abuse was present, but the child denied the allegation. Numerous situations of this combination appeared along with other reasons. Obviously, if the child denies the allegation - validation is much more difficult.

A large number of cases involve allegations, sometimes from anonymous complainants. Upon investigation, there may be no evidence of sexual abuse. Workers are frequently suspicious of abuse, but the signs or symptoms could not be verified. Cases of this nature frequently involved a follow-up on past offenders, or a complaint by other workers.

In some cases, the complaint was difficult to validate due to the circumstances involved in the case. For example, the complaint involved a child who was too young to be interviewed (age 2 or 3). Some were custody cases where parents contaminated the evidence and the child denied the allegation. In two isolated cases, the victim had fabricated the assault, and in another the child was confused over what constituted sexual abuse (this was a complaint based upon "touching").

A number of cases were not validated because the victim or the offender left the province. Some cases were based upon investigations of abuse in other provinces or investigations conducted for abuse complaints in other jurisdictions. Finally, a number of victims wanted no further action taken for a wide range of reasons - fear of not living at home, it had stopped, they felt they had enough difficulties in their lives, and fear of the consequences for themselves and their families.

Several cases involved young children who were both victims and offenders. The parents preferred to have it dealt with through a therapist or to take no further action on the complaint.

Denial of the allegation by the victim is a recurrent theme. In some cases, the intake workers are still suspicious with little verifiable evidence. The file would remain open for a long time in those cases. In others, however, the hearsay allegation appeared groundless and the victim denied the abuse had taken place.

III.1d VICTIM AND FAMILY PROBLEMS

When the victim's problems are examined in conjunction with family problems - as the number of family problems increase so do the victims. It is interesting to note that 31% of the cases indicated neither victim nor family problems. In other words, two situations emerge. When the family problems are low, the victim's level of problems decrease. This is not the general rule, but the pattern is present. Second, when the list of family problems moves beyond three in our list, the number of victim problems begins to concentrate at the level of three or four.

In cases of extra-familial abuse, nearly 50% showed neither problems for the victim nor family. In contrast, 25% of the intra-familial cases had a similar pattern. In both situations, however, large numbers of family problems appeared to be associated with higher levels of victim difficulties.

When type of abuse is examined in relation to the victim's problems, 53% of the cases indicated no problems. However, in intra-familial cases this is reduced to 35% and in extra-familial cases it is raised to 69%. This is not to imply that victims who have been abused by an offender outside of the family, have no problems. Those who had difficulties were concentrated at levels of three and four problems when the abuse was fondling, oral-genital contact or intercourse.

In intra-familial cases, 65% had problems of the type previously mentioned and they tended to be of the higher levels and associated with intercourse or oral-genital contact. Even fondling, however, was sometimes associated with high levels of problems.

When the second type was examined, they accounted for 75% of the cases. The combinations, as noted previously, (intercourse and oral-genital contact) and (oral-genital contact and fondling), 45% of those cases had high levels of problems usually of a behavioral and emotional type. The pattern held in both intra and extra-familial cases.

When number of incidents is examined in relation to the number of problems the victim exhibited, 60% of the cases had no problems despite the number of incidents which ranged from one to more than twenty incidents. As the incidents moved beyond three, more problems began to appear but in no linear pattern of increasing numbers. This was true for both types of cases.

Fifty-three percent (53%) of the males and females appeared to have none of the problems listed. However, that figure comprised 75% of the males and 50% of the females. Females had nearly equal percentages of problems from one to four, approximately 11% for each. This distribution was somewhat similar in both intra and extra-familial cases.

Age was not associated with the level of problems in 53% of the cases. The remainder, however, tended to indicate an increasing number of problems, especially after the age of eight. This was evident in both types of cases, but more so in intra-familial cases.

In general, the longer the complaint path, the more problems the victim had. As we moved beyond four steps in the path, higher levels of problems began to consistently appear. This pattern was pronounced for both types of cases, but more so for intra-familial ones.

One would have assumed that the victim would have had fewer evident problems the sooner a disclosure occurred in a complaint path. This did not appear to be the case. The contrary appeared in many cases. For some, the longer the path the more problems appeared. In others, however, many short paths had higher levels of problems when disclosure had occurred in the second or third step. This was most apparent in intra-familial cases.

In the data schedule for past cases, the kind of intervention for each case was recorded in terms of both types of interventions and additional service given to the client. The following table provides aggregate percentages, the types of interventions, and if additional Social Services were provided. Some of those additional services may be a few or many, sometimes as high as seven or eight for a victim and family including financial assistance.

TABLE 3.1

INTERVENTIONS 1986-89 n = 79

		YES	NA/DK*
A.	Victim Removed from Home	21.0%	16%
B.	Victim and Mother Removed	2.5%	20%
C.	Victim and Mother Left Voluntarily	5.1%	21%
D.	Victim to Foster Home	13.9%	15%
E.	Offender Left Home	29.1%	15%
F.	Offender Sent to Court	46.8%	9%
G.	Victim Testified in Court	10.1%	19%
H.	Victim Referred for Therapy	65.0%	10%
I.	Family Referred for Therapy	49.0%	9%
J.	Additional Social Services	42.0%	18%
K.	Offender to Therapy	42.0%	17%

*Not Applicable or Don't Know

Most cases in this time period had multiple interventions. On average there were four interventions per case and as many as seven occurred in some cases. These lesser interventions were typically associated with intra-familial cases.

With regard to therapy and other social services, they were typically associated with intra-familial cases. Interventions in extra-familial abuse were low to moderate. This figure could be misleading because our research seems to indicate that only more "severe" cases of extra-familial abuse were reported to Social Services, even if charges were laid in the case.

The above data not only indicates that interventions in the family tend to be major, but also the use of additional social services is quite high. Service use is more fully explored in the present cases. It is also significant, for example, that offenders going to therapy is almost as frequent as victims and families being referred to therapy.

III.2 PRESENT CASES

During the needs assessment, data schedules similar to those used for past cases (1986-1989) were used for cases that were currently in the system as of March, 1980. Each case involved a complaint which was being investigated by Social Services. They would obviously be in various stages of investigation, continuation or closure. Data was analyzed separately, to identify the nature of complaints that were in the system and cases that were verified as child sexual abuse cases. The following discussion will use both data sets to provide an understanding of the nature and characteristics of abuse and the nature of cases that are in the system at any point in time.

At the end of the period of data collection, there were ninety complaints in a little more than nine months. Upon further analysis, 43 cases (48%) had been validated by this point in time. In the remaining cases, 17% did not appear to have evidence of abuse, and in 20% there was insufficient evidence at that time, and 15% were only starting their investigations.

In terms of complaints, 19% were in Prince County, 70% in Queen's County and 11% in King's County. Approximately 65% were rural in origin. A somewhat similar distribution existed for the location of the abuse when examined with residence of the victim.

For the cases that were currently verified, 30% were in Prince County, 54% in Queen's and 13% from King's County with nearly the same distribution for rural (69%). These results are quite similar to those reported in past cases from 1986 through 1989. Likewise, nearly 75% of the cases occurred in rural communities.

Obviously during the research period, the numbers of complaints had increased which had also been somewhat evident in the previous two years of records. The number of verified cases has doubled over the previous researched period. It is impossible to definitively state that the rates of abuse had increased - determination of that was not a goal of the needs assessment. One must note, however, that there is more compliance in reporting incidents of abuse and an increase in following the reporting protocols with Child Welfare Services.

We should note that just after the close of the data collection a large number of complaints had been received by Social Services, some involving multiple victims, one case with a large number of victims. Obviously, the total complaints for the study period would be increased by ten to fifteen percent.

Ages of "victims" in the complaints ranged from two to seventeen years of age with an average of eleven and a standard deviation of 8.3 years. Twenty-five percent (25%) involved children who were under five, 25% were from six to ten, and the remaining 50% were from eleven to seventeen, the majority under 15 years of age. Females were in 89% of the complaints and 11% were males.

TABLE 3.2
Age-Sex Distribution of Child Sexual Abuse Victims

		Past Cases					Present Cases			
		Female	Male	n	(%)		Female	Male	n	(%)
Age	1	0	1	1	(1.3)		0	0	0	(0.0)
	2	0		0			2	0	2	(4.7)
	3	3	2	5	(6.3)		3	0	3	(7.0)
	4	4	2	6	(7.6)		0	1	1	(2.3)
	5	3	0	3	(3.8)		2	0	2	(4.7)
	6	3	0	3	(3.8)		1	0	1	(2.3)
	7	2	2	4	(5.1)		1	1	2	(4.7)
	8	3	1	4	(5.1)		1	1	2	(4.7)
	9	7	0	7	(8.9)		4	0	4	(9.3)
	10	6	0	6	(7.6)		2	0	2	(4.7)
	11	3	1	4	(5.1)		4	0	4	(9.3)
	12	8	1	9	(11.4)		4	0	4	(9.3)
	13	4	0	4	(5.1)		2	0	2	(4.7)
	14	7	2	9	(11.4)		4	0	4	(9.3)
	15	9	0	9	(11.4)		2	2	4	(9.3)
	16	2	0	2	(2.5)		5	0	5	(11.6)
	17+	0	0	0	(0.0)		0	1	1	(2.3)
	n =	67	12	79		n =	37	6	43	
		(85.0)	(15.2)				(86.0)	(14.0)		

Of the cases that had been validated, 86% were females (n = 37) and 14% were males (n = 6). These percentages are quite similar to the proportions in the past cases (see Table 3.2). The ages ranged between three and sixteen, with an average of eleven and a standard deviation of seven and half years. Fourteen percent (14%) were children under four, 30% were from five to ten, and the remaining 56% were fairly equally distributed from eleven to sixteen. In comparison to past cases, slightly fewer than 50% of the victims were under ten years of age.

Multiple victims were identified in 40% of the complaints. When the complaints were validated, 30% had more than one victim. In the cases of multiple victims, 16% of them were siblings, 7% a peer, 25% were another relative, and 21% involved a victim who was not related.

The number of multiple victims ranged from one to four other victims. One other victim occurred in 14% of the cases, two other in 10% of the cases, three others in 7% of the cases, and 3% had four other victims.

In the verified cases, the victims age when they were first abused was between two and sixteen. The average age of first incident was seven, with a standard deviation of nearly five years. Thirty-six percent (36%) were under five years of age when they were first abused, 27% were from six to ten, and the remaining 37% were from eleven to sixteen. We should note that in 40% of the cases the abuse started in the same year of the complaint. In the remaining cases, 37% were being abused for more than one year and up to six years. In the other 23%, they didn't know how long the abuse had lasted.

The number of incidents ranged from one to over one hundred. In 46% of the cases, there were multiple incidents, but the exact number was not known. Of those cases where some accurate estimates could be made, two or more incidents appeared in 70% of the cases. If we examine five or more incidents of abuse, it had occurred in 37% of those cases where estimates could be made.

The victim's relationship to the offender varied in the complaints. Thirty-seven percent (37%) involved intra-familial abuse, 28% involved a relative of the victim, 32% were neighbors, friends, persons in trust, and baby sitters. Strangers only accounted for 6% of the complaints.

When the complaints were validated, 38% were intra-familial (22% parents). Thirty-three percent (33%) were relatives and 18% were neighbors and others. A noticeable difference occurs between complaints and validation in extra-familial cases involving neighbors and others.

The abuse occurred in the victim's home in 60% of the cases. Twenty-three percent (23%) occurred in the offender's residence. The remaining cases (17%) happened in a variety of places ranging from the neighborhood to public places. As in the past cases, when number of incidents are analyzed with locations of abuse, the major proportion (90%) occur in combinations of the victim's and offender's homes.

The ages of the offenders in the complaints varied very slightly with those cases that had been validated. Forty-four percent (44%) of the offenders were under eighteen years of age. In the past, 30% were in the same age group. Forty-two percent (42%) were between twenty and forty years old and 20% from forty-one to seventy years old, the majority being under fifty-two years of age. In 20% of the cases, the exact age of the offender was not as yet known. Males were the offenders in 95% of the cases (n = 37) and females (n = 2) in 5% of the cases. Three of the offenders had previously been charged and convicted of sex offenses. Four of the offenders had previous treatment for sex offenses. In most of the other cases, the information was not available.

III.2a FAMILIES

The families of the victims were predominantly nuclear (68%), 18% were step-families, 11% were common law arrangements and one child was in foster care. Forty percent indicated some degree of family conflict and 44% were unstable. A history of either spouse abuse or child abuse was present in 28% of the families of the victims.

Thirty-five percent (35%) of the fathers were employed full time as were 33% of the mothers. In 40% of the cases the father had a substance abuse problem as did 23% of the mothers.

In terms of victim or family problems, 27% of the victims had previous emotional, behavioral, or academic problems and 40% of the families had employment, substance abuse, financial, child-parent and other types of difficulties. Family data is more applicable when intra and extra-familial cases are examined separately.

In terms of patterns, much of the intra and extra-familial patterns identified in the past cases were similarily evident in the present cases. Several additional patterns should be noted. The age of the child in extra-familial cases in terms of their first abuse incident appears to be associated with more family problems - the more family problems the younger the age of abuse (less than age 7). In intrafamilial cases, this pattern was not evident. Likewise, as in past cases, where the family has no problems, age of abuse is evenly distributed across all age groups.

In terms of previous family problems, 46% of the cases of intrafamilial abuse had indications of a history of child abuse and 69% had some forms of marital conflict. In extra-familial cases, there was evidence of less than 10% of either situation in the victim's family.

In the intrafamilial cases, 50% had a previous history of spouse abuse. Less than 10% appeared in extra-familial cases. Eighty-six percent (86%) of the intrafamilial cases had evidence of both. A history of child abuse was not associated with socio-economic factors in either type of case. Twenty-nine percent (29%) of the cases of intrafamilial abuse showed both histories of substance abuse and child abuse, while 42% showed neither.

It is interesting to note that in 78% of the cases with more than one incident of abuse, children had been abused two or more times, and as many as eight and twenty-four times before disclosure. One would have expected a much lower percentage in this variable. In fact, percentages for multiple incidents of abuse were similar for both types of cases.

Fifty percent (50%) of the cases of extra-familial abuse involved two or more incidents, especially in the age group under twelve. On the other hand, multiple incidents in intrafamilial cases increased with age after the victims were ten years of age.

The abuse of females in extra-familial cases was of a more severe nature than intrafamilial cases; 40% involved anal or vaginal intercourse, whereas this occurred in 20% of the intrafamilial cases. Fondling was the most common form of abuse in both types of cases. Intercourse was more common among younger victims (extra-familial) and older victims (intrafamilial).

Violence and coercion had been used nearly equally (50%) in both types of cases irrespective of age or the sex of the victim.

The complaint paths for extra-familial cases were longer than abuse in intra-familial cases - a pattern present in the past cases as well. Fifty-two percent (52%) of the extra-familial cases had five or more steps - only 28% in the intra-familial cases.

Age appeared to have a mixed effect on extra-familial cases. When the victim was six or under the path was shorter (2-4 steps). As they became older, the steps tended to increase. Age in intrafamilial cases seemed to shorten the number of steps. Contrary to the past cases, many cases involved disclosure at an earlier point - within two to three steps. We should caution the reader that these are based upon validated cases. Many are still under investigation and in a number of them, the victim has denied that the abuse occurred.

It is interesting to note that in the intrafamilial cases, mothers were not always the first person disclosed to, although they were the complainant in 16% of the cases. On the other hand, mothers (32%) and fathers-parents (14%) were disclosed to in the extra-familial cases.

Where disclosure was to school personnel in extra-familial cases, the paths were long. In intra-familial cases, they were short.

Charges were laid in 44% of the extra-familial cases, but in 17% of them, workers were unsure if they would be laid. Charges were laid in 23% of the intrafamilial cases. In 31%, they were not sure or didn't know if charges would be laid. The proportion of cases with charges laid for female and male victims was nearly equal. Charges tended not to be laid for young victims (under 10) in intrafamilial cases. No discernible pattern existed in extra-familial cases.

Data Schedules were used on all present cases when the case had been closed or when the data collection period finished. Some of that data will be discussed in other sections on victim or family needs.

Victims in the present verified cases (n = 47) primarily came from families of four or less members (75%), typically having no brothers (34%) or one brother (42%) and no sisters (37%) or one sister (37%). Sixty percent (60%) were nuclear families, 14% step families and 27% some common law arrangement.

The education of the parents varied widely. Mothers had 20% grade 9 or less, 23% grade 12 or less, and 24% some university or specialized training. In 33% of the cases, level of education was not known. In terms of the victim's father, 36% had grade nine or less, 13% grade ten to twelve, and 13% had some university or specialized training.

Data schedules at the second point in time also obtained information on the level of verification in the case. In the cases that had been verified, 85% of the child's statements supported the complaint, in 80% of the cases the child's behavior supported the complaint, 71% of the family's statements supported the complaint, 72% of the family's behavior seemed to support the complaint, 10% of the medical evidence, 61% of the police investigations, 47% of the siblings' statements, and 53% of the witnesses' statements.

A total of twenty-five social workers and seven supervisors had been involved in the 42 cases that were validated. The average being two workers per case. Some workers, however, had been involved in four and as many as eleven cases. The cases involved from less than ten hours to as many as 90 or more hours. Twenty-nine percent (29%) were ten hours or less, 35% were between eleven to thirty hours, 12% involved thirty-one to fifty hours, 10% between fifty-one to seventy hours, 2% between seventy-one to ninety hours, and 12% more than ninety-one hours.

Using mid-points of time intervals and frequencies, a crude estimate of time can be estimated at thirteen hundred and sixty hours for the validated cases creating an average of 32.4 hours per case. The standard deviation is approximately 27 hours. Note that these are validated cases, this does not include complaints which have not been validated. Those investigations also can involve thirty to forty hours.

III.2b CASE PROBLEMS

During the course of the needs assessment, intake workers completed a Case Problems Index which is more fully described in the methodology section. In short, it attempted to itemize the difficulties that occurred during the course of the case. As we have noted, cases were in varying stages of completion and we have adjusted percentages to accurately represent the number of cases that were at a particular stage of the intervention. We should also note that the index findings are based upon the experience of case workers who are interacting with victims, families, and other agencies.

Of the eight problems identified with victims, case workers had 42% of these cases with no problems connected or related to the victim. Thirty-seven percent (37%) of the cases had one or two problems and 12% had three or more problems. The problems that appeared most frequently were (a) the victim was very young (20%), (b) the victim's cooperation with the investigation (15%), (c) the victim's cooperation with the therapy plan or case plan (10% each), (d) the fear of being labelled (14.5%), and (e) the victim was receiving insufficient support (14%). The items independently are not significant. Their significance occurs when they are combined - two, three or four of them.

A second area that was examined may be difficulties that the victim or the case worker may experience with the family. In 21% of the cases, there were no problems with the family of the victim. In 42% of the cases, there were one or two problems, 20% of the cases had three or four problems, and 13% indicated five to seven problems.

The problems that most commonly arose out of the nine possible were: (a) the family was a multi-problem family (52%) - these were discussed previously, (b) difficulties in validating the abuse with the family (38%), and (c) insufficient familial support for the victim (29%). The second most common set of problems were: (d) family cooperation in the investigation (18%), (e) cooperation with the case plan (23%) and (f) cooperation with the child's therapy (18%). Cases with five or more problems would have included most of the above.

The next area analyzed was in regard to problems related to the offender. Of the sixty-two cases examined, the offender was not really applicable to the case at this stage of completion in 25 cases. In 27% of the cases the offender created no problems for the victim or case worker. In 61% of the cases the offender created one or two problems. In 10% there were three to four problems. The more common difficulties were that in 13% of the cases the offender was interfering with the victim. In 24% of the cases they were interfering with the family and in 24%, with witnesses. In 44% of the cases, there was no available treatment for the offender.

The police phase of the investigation was the next area that was examined - with sixteen categories of problems. Of the cases examined, twenty-one of the victims had not completed the police investigation. In the remaining forty-one cases, 36% of the cases had not experienced any problems connected to the investigation. Twenty percent (22%) had experienced one to two problems, 27% three to four problems, 13% five to eight, and 10% nine to twelve problems.

The more frequent areas of difficulties were: (a) 48% in the police interviews, (b) experience in sexual abuse (26%), (c) the time delay in charges (27%), (d) the length of the investigation (26%), (e) the victim's situation during the investigation (22%), (f) protocols (19%), and the family situation (19%).

Of the sixty-two cases that were in Social Services files, eighteen had contact with the Crown Prosecutor's Office. Sixty percent (60%) had no difficulties during that contact. Sixteen percent (16%) had one to two problems, and 24% had four to nine problems.

The more frequently mentioned problems were: (a) case preparation (22%),

(b) use of expert witnesses (16%), (c) flow of information (22%), (d) sensitivity to the victim and family (22%), (e) access to crown (27%), and (f) notification and child sexual abuse dynamics (27%).

In Victim Services, sixteen cases had contact at this point in time. Fifty-six percent (56%) had experienced no difficulties. Twelve percent (12%) had one or two problems and 31% had three to seven problems. The more frequently mentioned problems were: (a) coordination with C.F.S. (42%), (b) coordination with victim (31%), (c) role clarification (31%), (d) approach to victim and family (25%), and (e) flow of information (27%).

In terms of court, thirteen cases were in court or completing the court process. Forty-six percent (46%) had no problems, usually because the victim had pleaded guilty. In the remaining cases, 30% had between one and three problems and 23% had six or more difficulties. The more frequent difficulties in the process were: (a) the length of time between charges and plea and the length of time before court (38% each), (b) the length of time between the plea and hearing and the time between hearing and sentence (23%), and (c) sensitivity to the victim and family (38%).

In Social Services, forty-five cases were in contact with the agency. Seventy-three percent had experienced no difficulties. Twenty-seven percent had experienced one to three problems. The more frequent problems were: (a) turnover of workers (10%), (b) insufficient case plan information (12%), (c) availability of services (6%). One should remember that many of these cases were still in intake.

In terms of therapy services for victims, thirty-four cases had come into contact through referral to these services at this point in time. Sixty-one percent (61%) had experienced no difficulties. Twenty-three percent (23%) had one or two problems and 15% had three to five problems. The more common difficulties mentioned were: (a) the nature of the therapy (20%), (b) waiting lists (29%), and (c) availability of services - usually distance (23%).

Therapy services for family members was applicable to 30 of the current cases who had been referred for service. Fifty percent (50%) had experienced no difficulty, 50% had experienced one to three problems. The more common problems were: (a) accessibility (26%), (b) cooperation (20%), (c) time delays with service (30%), and (d) availability of services for siblings (23%).

Thirty-six cases had contact with medical or hospital facilities. Sixty-five percent (65%) had no difficulties. However, 22% had experienced two to three difficulties and 12% had between four and six difficulties. The more common problems were: (a) sensitivity to the victim (17%), (b) court and waiting facilities (14%), availability of medical personnel (14%), (c) availability of experienced medical personnel (22%), (d) knowledge of medical evidence requirements (19%), and (e) willingness of personnel (14%).

In twenty-eight cases there had been contact made with the school system. In fifty-nine percent (59%) of those cases there had been no difficulties. Much of the contact with schools is made during the investigation phases of an intervention. More contacts are made in later phases although many of these cases had not proceeded to this stage as yet. In 17% of the cases, there had been one to three difficulties and in 27% of the cases there were five to seven problems.

The most frequent problems mentioned were: (a) school cooperation (21%), (b) role clarity (32%), (c) interviewing facilities and scheduling (25%), (d) protocols and reporting (28%), (e) over involvement (17%), and (f) confidentiality (14%).

III.2c TOTAL PROBLEMS IN CASES

The individual types of problems or categories of problems give us a sense of the nature of problems connected to a case of child sexual abuse for the victim, the family, and the people involved in the case. Some problems will affect the victim and family directly, others will affect them in an indirect fashion in terms of the investigation, testimony, collecting evidence from the offender, the family waiting for therapy and so on.

The total problems for each case were calculated to give us a sense of the level of difficulties in a case. The reader should be cautioned again with regard to the stage of intervention in each case. Nine percent (9%) of the cases experienced no problems. Forty-eight (48%) had experienced between one and five problems. Again the reader should realize that one problem in the family or in court delay can be very significant to the victim and/or the family. Eighteen percent (18%) experienced between six and ten problems. Twenty percent (20%) between eleven and twenty problems and 10% between twenty and fifty problems.

Although the median is between five and six problems and the average is ten problems, the intensity of effect of any one problem on a victim can be mildly or very harmful to the victim. Of second concern is the range of problems beyond the mean and median. Approximately 30% of the cases fall between the category of eleven and fifty difficulties. (In summary, a single category of problems may be problematic, but the multiplicity can be overwhelming to the victim, the family, and the professionals involved in a case of child sexual abuse once it is "known to the system.")

A second type of analysis is required with the data on case difficulties. As previously stated, many victims had not proceeded through an entire intervention and consequently the entire number of areas were not applicable to many cases. We have noted through the course of this section the numbers of cases which were not applicable at these different stages.

Of the ninety-three (93) problem areas available for each case, five thousand and sixty-six (5,066) were available to the cases in service at the time. Two thousand six hundred and eighty-one (2,681) were not applicable areas. This left three thousand and eighty-five (3,085) possible areas which leaves an average of approximately fifty per case. When total problems are calculated on average applicability of areas, a clearer picture of problem levels is obtainable which can be misleading when only aggregate percentages are used.

Consequently, using the end points of categories we obtain the following distribution of problems:

TABLE 3.3
CASE PROBLEM DISTRIBUTION

If a case has 5 total problems it indicates 10% of the areas encountered
" " " " 10 " " " " 20% " " " "
" " " " 15 " " " " 30% " " " "
" " " " 20 " " " " 40% " " " "
" " " " 30 " " " " 60% " " " "

For example, if a case identifies ten to twenty problems, we may say that 20% to 40% of the areas they have encountered are problematic. If we review our distribution of total problems, 39% of the cases had problems in 10% of the areas they have encountered. Eighteen percent (18%) have had problems in 20% of the areas encountered. Twenty-four percent (24%) have had problems in 30% to 40% of the areas connected to the case, and 10% have had problems in 50% to 60% of the areas they have encountered. Therefore, there is a somewhat higher distribution of problems experienced in cases.

In summary, the two previous analyses indicate that in some cases, levels of problems may be small. However, there are at least 35% of the cases with eleven or more problems. This also means that difficulties have been experienced in 20% to 60% of the areas the case has encountered. Second, we should caution the interpretation of less than ten problems encountered. It indicates that at least twenty percent (20%) of what they have encountered is problematic. A single category (e.g., family) may be problematic - with even one or two difficulties, but lack of support from the family may be very difficult for a victim or even waiting for court may be harmful. Lastly, as we move to the multiplicity of categories which are problems (e.g., cases with five or more problems - 50% of the cases), the multiplicity can become overwhelming to the victim, the family, and the professional involved in a case of child sexual abuse once it has become "known to the system."

A more in-depth discussion of these problems will proceed in the staff and agency sections of the needs assessment. A more detailed and in-depth analysis of case problems and outcomes will be presented in the planning phase of the intervention model.

III.2d PREVALENCE AND CASE DEMAND

Numerous reviews of child sexual abuse incidence and prevalence have appeared in the past few years (Haugaard and Reppucci, 1988; Painter, 1986). The definitions of sexual abuse are dependent upon criminal codes and child protection acts. They, therefore, significantly influence findings. And the nature of sampling has generated wide variations in estimates. Estimates, therefore, are functions of both method and definition because both affect populations studied and techniques employed (Painter, 1986). We may add that compliance with reporting to agencies and between agencies will influence both types of estimates. Suspected rates are high though, and warrant a significant concern regarding the nature of abuse and its effects upon victims.

Incidence typically refers to the increase or decrease of cases of child sexual abuse over any defined period of time. Prevalence, on the other hand, refers to a statistical proportion of the population who have been abused during the course of childhood. Canadian National Samples (Canadian Population Survey, 1984) reported that twenty-eight percent (28%) of women and ten percent (10%) of men had experienced a form of child sexual abuse. Reviews of past research on rates can only provide a sense of proportions, trends, and directionality, and there is great variability in the rates reported. The Peters et al. (1986) review of prevalence literature reports a range of 6-62% for females and 3-31% for males. Cantwell (1980) estimates that only 1 in 1,000 persons under 18 in an urban sample will formally report their abuse. Comparisons of differential rates suggest that variations between them are associated with other factors. For example, the Russell (1984), Wyatt (1985), and Finkelhor (1979) studies, suggest that rates among women in urban areas may be higher than in rural, and general rates among the "poor" may be significantly higher.

Reporting significantly affects the estimates of prevalence and incidence rates are suspected to be quite different between females and males. One could expect that incidence will have risen since the early 1980's due to a "slightly" more conducive environment to reporting and one may expect estimates of prevalence to increase in the next ten years, especially those figures based upon clinical populations (Salter, 1988). In the present assessment, the numbers of complaints and verified cases have more than doubled in the past few years. In addition, the expectation is that the proportion of high risk cases may remain but their numbers in reporting will increase by ten to twenty percent (10-20%).

After a considerable review of definitions and estimates of child sexual abuse, several estimates appear to be most applicable to P.E.I. In our analysis, these estimates provide an initial, but conservative, "guess" of prevalence in the population with a real expectation that prevalence will rise in conjunction with reporting significantly in the near future. Bagley's (1989) reanalysis of the Canadian Population Survey Data suggests that 21.9% of females and 9.4% of males under 18 years of age have been sexually abused. Finkelhor's two studies using college and urban samples (1979, 1981) found that 15% and 19.2% of females and 6% and 8.6% of males were sexually abused.

Based upon these estimates, we now feel that a "fair" initial estimate of incidence for P.E.I., while recognizing the rates of under-reporting for both males and females, would be 20% of the female population under 18 years of age and 6% of males under 18 years of age, with a suspected 6% variation in either direction (see Eckenrode et al., 1988). In this case, we would expect that the variation would logically go to 26% for females and 12% for males.

The following table provides an age and sex distribution for children based upon the 1986 census. The new census (1991) would require prevalence adjustments.

Ignoring the fact of reporting circumstances and the differences of median age of abuse for males (8.5) and females (12) according to Finkelhor (1984), an initial, very conservative figure would imply that 250 to 300 cases per year have occurred during the time period of the Bulger study which somewhat correlates with the previous expectation that only 5 to 10% of the cases of child sexual abuse will be reported, officially and unofficially. Assuming equal distribution across all age groups, a fair and less conservative estimate (based on estimate B) would provide for between 285 and 420 cases per year. With a reporting rate of between twenty percent (20%) and

TABLE 3.4

AGE AND SEX DISTRIBUTION FOR
CHILDREN ON P.E.I., 1986

	under 1	1-4	5-9	10-14	15-18	Total
Females	920	3,755	4,740	4,785	4,185	18,385
Males	1,045	3,895	5,030	5,200	4,485	19,655
Total						38,040

Estimate A. @ 20% for Females (18,385) Prevalence = 3,677
@ 6% for Males (19,655) Prevalence = 1,180
Total Prevalence = 4,857

Estimate B. @ 26% for Females (18,385) Prevalence = 4,780
@ 12% for Males (19,655) Prevalence = 2,359
Total Prevalence = 7,139

ten percent (10%), it nearly equals the current complaint and rates of validation, if we adjust for cases which go unreported to Social Services but are processed in the legal system.

Incidence is difficult to estimate on the basis of reporting cases or making complaints to social services. In addition, the differential rates of disclosure by age, sex, and relationship to the offender, as evidenced in the past and present data, make estimates unreliable.

Contrary to current estimates, incidents and reporting in Prince Edward Island is definitely a function of age and sex. The median age of reporting is ten years old which is slightly lower than reported age estimates. For males the age is 7.5 years, much of which is based upon complaints from others than the victim, and 10.5 years which has been based more on victim complaints in older females. The current case figures are eleven for females and eight for males and this varies by intra and extra-familial abuse. In intra-familial cases, the median age for females is thirteen and in extra-familial it is nine years of age.

Incidence for abuse then is probably age, sex and type specific. We do notice constant rates for reported cases over the past five years in some types of abuse (i.e., intercourse and oral-genital contact), however, there has been a marked increase in the number of cases of fondling in female victims. It is difficult to determine whether rates have increased or disclosure and reporting has increased. In any sense, it is safe to estimate that incidence may have increased slightly, as has reporting.

What is of significance at this point in time, is that there may be three to four hundred new cases in any one year. As reporting increases, the number of victims and families that the "system" must respond to will increase accordingly. This would mean, using current cases, that between 125 and 200 complaints will have to be investigated in any one year. Given the varying degrees of risk, services will have to be made available to those victims, members of their families and the offenders.

III.2e CASES IN THE SYSTEM

As previously noted, between one hundred to one hundred and five (100-105) complaints to be investigated will appear in one year in the Department of Social Services. With rates of reporting, we can expect another ten to twenty percent (10-20%) increase in the following year given trends over the past few years. This may be a conservative estimate with an estimated average of 32.4 hours/case in validated cases. This may be both higher and lower in non-validated cases. We suspect a high standard deviation in the distribution of hours/case of approximately 10 hours. This does not include the services open for the victim or family before the abuse.

The total number of services opened after validation in most cases was 196 which was an average of 2.5 per case. Of those services opened, 32 were protection and 28 financial assistance. Therefore in terms of the total cases (n = 79), 41% were protection and 35% were financial assistance.

In the current validated cases (n = 43), seventy-four (74) services had been opened, thirteen (13) of which were protection (30%) files. This figure will rise since so many of these cases are new complaints, likewise many were still under investigation. This created an average 1.7 services/case. The previous estimates are higher because the validated cases had been in Social Services for a longer period of time.

On the basis of complaints (n = 90), 174 services were opened. This was an average of 1.9 services/case. Thirty (33%) were protection files. Obviously, the numbers of services opened per case is slightly higher on the basis of complaints than validated cases of child sexual abuse.

In Mental Health Services, during the period from April 1, 90 to March 31, 91 there were one hundred and eighty-seven (187) child sexual abuse referrals opened. They were 118 adult survivors, 34 child sexual abuse victims, 22 adult offenders and 13 adolescent offenders. As of April (1991), 93 cases were active in Mental Health Services. This figure is actually higher because the conversion to a new computerized report system was not complete yet. This figure may require adjustment. The Department of Justice will have approximately 40-45 active cases in probation, in one year. In their system at present there are 10-12 in the correctional facilities and 1 young offender. These figures do not reflect those cases that have been referred to private agencies, nor support services for victims, family members or offenders.

Excluding offenders in the Justice system, we can make some conservative estimates of the number of cases in the system (Social Services and Mental Health excluding Private Agencies and Support Groups). One hundred to one hundred and five (100-105) cases in Social Services with two services opened for each case. Validated cases will probably average fifty (50) or higher/year with current reporting trends. In Mental Health Services, 190 referrals/year which include assessment and therapy with probably a "conservative" average of 93 cases open at any point in time. Of those cases in Mental Health Services which are child sexual abuse related, 25-30% will be children who are victims (n = 23). In addition, of the 93 open cases, 58% (n = 54) will be adult survivors. Time estimates per case are difficult to estimate, but ten to twenty hours/case (10-20).

Based upon estimates in Mental Health cases can very dramatically in hours of required time. A "light" case may range from twenty to twenty-five hours (20-25). A "moderate" case from sixty to seventy hours (60-70) and a very difficult case can involve 100 to 120 hours (100-120). This time would include assessment, parental sessions, group work, clinical hours, possibly siblings, and case conferences with foster parents, counsellors and social workers. In addition, reporting and records and a large amount of time can be put into court appearances and court preparation. Difficult cases may also involve hospitalization and psychiatric involvement.

As we have noted previously in this section, an initial but conservative estimate is that the average validated case requires about thirty-four hours in Social Services intake. However, this is based upon a very bi-modal distribution with a high standard deviation of 27 hours. In addition, this estimate does not include the hours spent on investigations in non-validated cases. Those average hours are also bi-modal and can only be "guessed." They, on average, can involve twenty to forty hours (20-40) and the file may be open for a considerable time, if there is denial and the social worker still suspects abuse. In addition, all these estimates are based on new cases where interventions in many cases are not complete. An intervention from the Social Services and Mental Health perspective may last for some time and services may be delivered for a number of years.

IV. NEEDS AREAS - VICTIMS

IV.1 INTRODUCTION:

The major purpose of this study is to examine the experiences of children in the intervention system as a means of identifying their needs and assessing how well these needs are being met. The children who enter the intervention system have been wounded to different degrees by their experience of abuse, depending upon a wide range of factors like the nature and duration of the abuse, the age at which it occurred, the relationship to the perpetrator, and the degree of force used. Children also enter intervention rooted in the experiences of their own families and histories, possibly nurturant and supportive, but sometimes filled with conflict and dysfunction. Children themselves, may have attributes that could possibly provide some insulation against the effects of abuse, such as a well developed self-concept, or attributional styles free of self-blame. But regardless of what characteristics, behaviour problems and families that children present themselves with, they are victims. Their experience of sexual abuse brings them to the attention of helpers, and their well being becomes the responsibility of the intervention system. And before the intervention system can help them, it must first do no harm.

The model of traumagenic dynamics developed by Finkelhor & Browne (1985) introduced earlier provides a useful framework for conceptualizing the effects of sexual abuse. Many of the problems in the lives of the children and adult survivors discussed above can be seen as stemming from these dynamics. For example, the sense of betrayal in early life can impair judgment about the trustworthiness of others and disturb future relationships (Briere, 1984; Courtois, 1988) or contribute to future physical and sexual abuse (DeYoung, 1982; Fromuth, 1986; Russell, 1988). Stigmatization may contribute to feelings of isolation and loneliness, and a sense of guilt, shame and low self esteem so evident in some of the narratives that follow (Herman & Hirschman, 1977; Summit & Kryso, 1978). Powerlessness is reflected in numerous symptoms related to fear and anxiety, and to various behavioral problems associated with control (Burgess & Holstrom, 1978; Gelinas, 1983; Friedrich, Urquize & Beilke, 1986; Summit, 1983). Finally, traumatic sexualization directly contributes to sexual difficulties ranging from fear to the absence of arousal to compulsive sexual activity.

But the effects of sexual abuse are not only a function of preabuse factors and abuse characteristics. They are also related to events that follow disclosure. The effects of parental reactions to abuse reflect the importance of the victim's support system in limiting or exacerbating the effects of abuse (Adams-Tucker, 1982; Arbuckle, et. al. 1989; Conte & Schuermann, 1987; Courtois, 1988; Gold, 1986: Herman, 1981; Rogers & Terry, 1984; Schultz, 1979; Tufts, 1984). And the intervention into the life of the child and family also has the potential to "touch" the victim in ways that may reinforce rather than ameliorate the effects of abuse. Rivera (1988) found a number of the families she interviewed reported negative experiences with different aspects of the intervention system. Other authors have observed that the court system may have negative consequences for victims that may strengthen abuse effects (Berliner & Barbieri, 1984; Newberger, 1987; Runyan, 1986; Runyan, et. al, 1988; Weiss & Berg, 1982). Tedesco & Snell (1987) found that helpfulness of investigative interviews was negatively related to the number of interviews conducted, and another study (Runyan, et.al., 1988) found that victims with a shorter court process showed more improvement in symptomatology than those whose court experience was more prolonged.

Thus, the experience of victimization is not limited to the abuse itself, but may extend into the social and institutional response to abuse. And children's feelings in their encounters with others, whether they are family members, helpers or people in the community may be very similar to those experienced as a function of the abuse itself. "Disbelief and rejection by potential adult caretakers increase the helplessness, hopelessness, isolation and self blame that make up the most damaging aspects of child sexual victimization," (Summit, 1985). The same harmful dynamics that constituted the central aspects of their experience as a victim identified by Finkelhor & Brown (1985) i.e. powerlessness, stigmatization, and betrayal of trust, may be present in their relations with others, and in their experiences with intervention.

This is the core then of a "secondary victimization". As the child goes through the process of intervention following disclosure, all those who come into contact with her (and the "processes" she[1] must go through) may "touch" her in ways that are supportive, helpful and affirming or may recreate the feelings of betrayal, powerlessness or stigmatization. The ultimate revictimization would of course be additional traumatic sexualization by others. It is a major focus of this study to learn about children's experiences of victimization and support during the entire process of intervention.

IV.2 GENERAL PLAN: Many of the data sources discussed in the previous section will be utilized in the discussion of the experiences and needs of victims. The discussion will be organized around the primary data of the child's experience, the family's perceptions of her experience, and the experiences of adults survivors. The problems in the intervention system identified by children, families and survivors, and their suggestions for solutions are key ingredients in the process of clients' identification of their own needs, and are presented here. The organization of this section will follow children through the systemic process from disclosure, through investigation, intervention, therapy and court. At the center of this description will be the narratives of children and their families about their experiences with these different processes, as well as their advice, and the advice and experiences of adult survivors.

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[1] "She" is used throughout this section of the report. This is not meant to detract from the fact that there are a large number of male victims but rather it is used in a generic sense to indicate the predominance of female victims.

Additional sources of data (e.g. case records data, data schedule, information from therapist interviews, information about children in therapy, survey of school guidance counsellors) will be included that is relevant to each of the different "process" areas. While some of these other sources of data consist of observations about the children we interviewed, we will also present information drawn from the profile of recent cases (e.g. case records), perspectives about the dynamics, needs and problems of sexually abused children in relation to the intervention process (e.g. from interviews with therapists) as well as other relevant information for understanding their experience of different aspects of intervention.

IV.3 DIRECT DATA GATHERING FROM CHILDREN, FAMILIES AND ADULT SURVIVORS - THE INTERVIEW AND ASSESSMENT PROCESS

1. The Samples of Respondents

a. Proposed Samples. In the initial proposal for the needs assessment, we planned interviews with three samples of victims:

(1) Present/in - those children who were in the intervention system when the study began (June, 1990) or who entered it during the study period. This group was felt to represent the best source of information about the immediate effects of the abuse, the needs that children bring to the therapy/intervention system, and how effectively the intervention system is responding to those needs. We planned to assess these children twice, with psychometric testing being done both "early" and "late" in their intervention experiences during the study period as a means of assessing intervention effects. Interviews were to be done during the second ("late") session to maximize information that could be gained concerning their perspectives on the services system. We planned to interview the families of these children as well, and hoped for a sample of 40-50 "present/in" cases.

(2) Past/in - children who had been in the intervention system whose cases had been "closed" in the two years prior to the study. These respondents were felt to offer the best perspective on the full spectrum of the intervention system and its effects, and were in a unique position to provide valuable advice about what needs to happen in the response to sexual abuse. Psychometric tests would be given during the single interview session, and families of these children would also be interviewed. We hoped for a sample of 50 of these "past/in" cases..

(3) Never/in - recent and adult survivors who were never in the formal intervention system as children. These respondents were felt to offer valuable insight into the considerable barriers to disclosure, the long term impact of sexual abuse, and the process

of recovery. As key informants, their perspective was regarded as very important in the design of a safer system for children more oriented toward their therapeutic needs. As young adults and adults, we also felt that they might be able to articulate some unspoken needs of children more clearly. No testing was proposed with this group of respondents, and we planned to interview a sample of 25.

b. Accessing respondents. Gaining access to respondents became one of the major challenges to this study. The plan to access that we developed was to utilize those persons with supportive relationships with children and families to introduce the project, and therapists became our "first line" of access. While the interviews themselves did not directly address the abuse experiences and were designed to be as supportive and empowering as possible, it was clear that they had the potential to raise very sensitive issues for the children and parents. Accessing through supportive persons provided a resource for respondents to consult with should such issues arise.

Shortly after an informational newspaper article about the project appeared, therapists were asked to contact mothers or guardians of their current and past child clients with histories of sexual abuse.Therapists were provided with an explanation of the project to present to the mothers or guardians when they called or personally spoke with them. It was stressed that there was no relationship between the study and the therapeutic process, and that participation was completely voluntary. While the presentation indicated the research teams' interest in speaking with both the child and mother (in separated interviews), it was also clear that we were also interested in interviews with the mother alone if she was reluctant to have her child participate. If they indicated possible interest in the project, the therapist offered to send additional information. A consent to release information form was included in the mailout. Therapists allowed 1-3 weeks for mothers to consider participating and/or consult with their child before making a follow up call.

If mothers/guardians agreed to participate, they were asked to sign a consent form allowing the therapist to release their name and specific information to one of the interviewers. The specific information included the age of the victim at the time of the abuse, her relationship to the perpetrator, how long the abuse lasted, when it happened, the therapist's rating of the "severity" of the abuse, and the address and phone number of the child and family. Since the interviews with children and mothers did not directly inquire into the abuse incidents, this information was requested to help "orient" interviewers to the basis of the child's experience. Once the release form was signed, therapists would contact an interviewer and provide the name and specific information.

Therapists submitted lists of all clients they planned to contact to a central "registry" of two persons (one from Mental Health, and one from Social Services) who kept track of all participants, coordinated agency file numbers and oversaw the protection of client confidentiality. Once therapists had submitted their lists, Victim Services workers (in the Department of Justice) submitted lists to the "registry" of their clients/families who they were willing to contact. The registry persons excluded any names of clients that therapists were contacting, and returned the revised lists to the Victim Services workers. The workers then went through the same access procedure with their clients as the therapists. Finally, a similar process was carried out with Social Services workers. While this procedure proved to be rather elaborate, and very time consuming,it was successful in preventing any client from being contacted by more than one agency. It was also another small reflection of the level of interorganizational complexity that has evolved around the response to sexual abuse, as well as the complexity of the procedures of required to study it.

Therapists were also the principle avenue of access for adult survivors. Victim Services workers were also asked to make referrals to the project when they knew the clients they had were not in therapy.

For all samples, we attempted to access respondents from both public and private agencies, and from agencies located in all areas across the Island as a means of getting the broadest perspective on available services. This included six therapy agencies, five regional offices of Social Services, Victim Services in each of the three counties, and two independent therapists.

Newspaper advertisements were also run several times during the course of the project, inviting the participation of families and children, survivors, and persons with experience or perspective with "special needs" groups.

c. Description of the Samples. Extensive problems with the access process resulted in some major revisions to the both the nature and size of samples and the data collected. While discussions with agencies began in June, 1990, it was January, 1991 before a child or family was actually referred to the project. Second, the number of referrals was smaller than anticipated. Third, the number of present/in cases in the therapy system, our first line of access, was quite low during the study period (although the number of cases in social services surprisingly was not). For these reasons, we were unable to gather adequate separate present/in and past/in cases, and they have been combined into one sample. Due to the relatively short period of data gathering (4 months), we also decided that the repeated measures on the psychological tests would not be particularly useful and the amount of psychometric data gathered was quite limited because of the length of our interview process. Consequently, our analysis of the data has needed to be more descriptive and far less oriented toward evaluating effects or outcomes than we had originally planned.

(1) The sample of children. Thirteen (13) children were interviewed for the study. They ranged in age from 7 to 18 years ($\bar{X}$=13.2). Two were boys and 11 were girls. Eight of these children were still involved in some aspect of intervention, while the remainder were "past" cases. Nine had been abused by members of their families, five by their

biological fathers. Referrals of children were primarily from therapists (n=9), with others from social services (2), victim services (1) and one self/mother referral.

Interviews with children generally lasted 1-2 hours.

(2) The sample of families. A total of 26 parents were were interviewed. In the case of 9 of these families, their child was also interviewed. One respondent was the child's father while the remainder were mothers.

(3) The combined sample. When both the children interviewed and parents interviewed are considered together, there are 30 cases that comprise this "total"sample, and much of what is reported draws upon this combined sample. In this sample, 90% of the sexually abused children were female, and 10% were male. The sample consisted primarily of intrafamilial cases (76.6%). In 43.3% of the cases, the child was abused by either a biological parent or a step parent, while the perpetrator was another adult relative in 16.7% of the cases and was a child relative (brother, cousin) 16.7% of the time. The remaining 23.4% of the children were abused by neighbours, acquaintances and a cab driver. All perpetrators were male. In one case, the respondent was the mother of boy whose alleged abuse of his sister was reported by someone outside of the family where no abuse was validated and the investigation dropped. There were three families where more than one child was abused , and two children had more than one perpetrator. Children in the sample had disclosed their abuse beginning at age 2 1/2, and on the average, at around 9 years.

Data on the nature of the offense was obtainable in 79% of the cases. Fondling and masturbation are the most common types of activity (56%), while 13% of the children have experienced digital penetration or oral sex, and 30.4% have been subjected to attempted or completed intercourse. On the average, the sexual abuse had gone on for about 20 months prior to disclosure.

Half the referrals (50%) were from therapy agencies, while the remainder were from social services (20%), victim services (16.7%) and self-referrals (13.3%).

Family interviews generally lasted about 2 to 2 1/2 hours. A number of the mothers completed the Child Behaviour Check List on their children. (N =18).

(4) Adult Survivors. A sample of 27 adult survivors was interviewed. The sample was principally female (89.3%), and many of them were self-referrals to the project (N = 12). The remainder of the referral sources were evenly divided among therapists in the public agencies, in the private and community agencies , and from Victim Services . A number of self referrals had also had experiences with local therapy agencies and self help groups. They ranged in age from 23 to 54 ($\bar{X}$=33.7 years). Their histories of abuse were extensive, and almost half (48.1%) had been abused by more than one offender.

Of the 71 perpetrators by whom they were abused, 70 were male. On the average, their abusive experiences lasted approximately 5 1/2 years. Males experiences were exclusively with extrafamilial perpetrators, while in all female cases but one, there was a perpetrator from within their immediate family. In 10 cases, abuse was by a father or stepfather, while 13 survivors were abused by brothers.

These were very intensive interviews that generally lasted 2 1/2 to 3 hours.

2. The Interview Team. Particular care was taken in selecting sensitive and knowledgeable interviewers to deal with the personal and intensive nature of this interview process. The four women chosen all had experience in working with adults and children in the areas of family violence and mental health. Two were experienced in counselling sexually abused children, and a third had a good level of knowledge about the problem from courses and workshops. During the time of the study two were employed as mental health counsellors, one worked with children at a shelter for battered women, and one was employed as a youth worker. Women interviewers were chosen because we anticipated that the large majority of our respondents would be females who had been victimized by males, and believed that they would be more comfortable and open with women. One of the research consultants (D.M), a male clinical psychologist, conducted several interviews with children and an adult survivor as a means of developing and "piloting" the interview process. Male victims were presented with the choice of a male interviewer (D.M), but none selected this option.

Because of the level of experience of the interview team, the training prior to the data gathering process was not extensive. One day was spent with a clinician consulting to the project and focused on abuse dynamics and on exploring clinical issues related to the interview process. A second day involved description of the project, review of project materials and meetings with a Crown Prosecutor and a Social Services intake worker to help familiarize interviewers more with the intervention process. Once data gathering began, the interview team met regularly to discuss issues and experiences, to offer and receive feedback and to suggest ways of improving the interview process. The interview team also played a major role in the data analysis.

3. Analyzing the Data. While there are some quantitative questions in the interviews (particularly with families), most of the data consists of our interviewees' responses to open-ended questions. Since the aim of this interview format was to learn about our respondents' experiences from their point of view, it was important that our data analysis enable us to "create a rich description of the phenomena investigated from the perspective of the participants involved" (Moon, Dillon & Sprenkle, 1990, p. 363)." Therefore, we developed several methods of analysis for our qualitative data drawn from general approaches to qualitative methodology (Miles & Huberman, 1984), evaluation (Patton, 1987) and women's research (Women's Research Center, 1987; 1989). The major types of methods used involved (a) thematic analysis of individual interviews, and (b) content analysis of individual questions.

a. Children's Interviews.

(1) Thematic analysis. In learning about children's experiences primarily with intervention, but also in their families and communities following disclosure, our attention was focused then on the "continuum" of responses and reactions ranging from victimization to support. Many interview questions sought information about the responses of others and the feelings children had with others or during different aspects of the intervention process. At six points in the interview, children's reactions with others was assessed through the use of a "victimization-support" adjective check list, developed out of the work of Finkelhor & Browne and other ideas about victims (Janoff-Bulman & Frieze, 1983; Peterson & Seligman, 1983). There were and equal number (11) of supportive (e.g. accepted, cared for, informed, understood) and victimization (guilty, alone, helpless, scared) adjectives. Adjectives reflecting both the three key "traumagenic factors" (betrayal, powerlessness, stigmatization) and their "opposites" were included; for example, children may feel "scared" when powerless, and "safe" if they a sense of control.

The aim of the thematic analysis was to "tell the child's story" in relation to her experience of the systemic process of intervention. The thematic focus concerned identifying sources of victimization and support at the different steps in the process (1. Disclosure, 2. Investigation, 3. Intervention - Social Services, 4. Court - Criminal Justice, and 5. Therapy. For each of these processes, the interviewer was asked to write a brief **summary description** of the child's experiences in relation to victimization and support, and then to provide **supporting statements** for this summary using the child's own words. Interviewers drew upon working definitions of the victimization and support themes developed from the work of Finkelhor & Browne (1985), and others (Dawson, 1991; Janoff-Bulman & Frieze, 1985). The child's experience in each process was also rated on a 9 point scale of support-harmfulness, with a neutral mid-point.

After interviewers had completed summaries, supporting statements and ratings for each of the five sections of the interview, they provided three "overall" descriptions (with supporting statements and ratings) of victimization and support based upon the entire interview: (1) for the child's experiences with the entire intervention system; (2) for the child's experiences with their family; and (3) for the child's experiences in the community. The inclusion of the family and community analyses offered a perspective on important others within the child's social context who can profoundly affect her experience.

The separation of the thematic analyses into "summaries" and "supporting statements" provided a good means of assuring that descriptions were faithfully reflecting the primary data as much as possible. Both the summaries and the children's actual statements will be presented in the discussion of results.

(2) Content Analysis. For certain key questions, we wanted to identify the major common patterns and categories of responses present in the data. Thus, we were interested in using an inductive analysis to identify the "indigenous typologies" (Patton, 1987) within the data. In particular, we were interested in children's responses to questions of what had hurt them and helped them the most during intervention experiences, and in their responses to "key informant" questions about what needs to change to make intervention safer and better for children (or **Kid's Wisdom**).

For each of the 10 questions analyzed in this way, the verbatim responses of each child were recorded along with their coded interview number. Responses for each question were reviewed by two analysts (members of the interview and research team). Each identified central thematic categories for the responses and sorted each of the children' comments into categories. The two analysts then compared their themes and sorting of responses, and collaborated to arrive at a final analysis for each question. On most occasions, analysts were reasonably close in their themes and sorting schemes. The final thematic categories generally account for all responses, or all responses but one or two. The same method was applied with similar results for content analysis of questions in family interviews and adult survivor interviews. After the procedure was well established, a single analyst sorted responses into themes.

b. Family Interviews.

(1) Thematic analysis. The interviews with families asked about the parent's perception of the child's experiences with intervention in addition to asking about her own experiences. Consequently, two thematic analyses were conducted for each family interview. (a) First, interviewers analyzed the interview using the parent as a source of information about the child. As above, the thematic emphasis was upon experiences of victimization and support in each of the intervention processes and the analysis was conducted in the same way. In a number of cases (N = 17), the parent is the only source of information about the child's experience since the child was not interviewed. (b) Second, the interview was analyzed in relation to the family's experience to provide a description of the response of others to them during intervention in relation tc victimization and support.

(2) Content analyses. All open-ended questions (N=62) were analyzed similarly to the content analyses for children's responses. Most of these questions focused on identifying helpful and harmful aspects of interventions, persons, systemic problems and suggestions for change.

c. Adult Survivor Interviews.

(1) Thematic analyses. Three areas were chosen as a focus for thematic analysis of these interviews: (a) disclosure and the history of silence. Since many of our respondents had not disclosed their abuse as children, we felt that this data would provide valuable insight how disclosure functions as a process, and into the formidable to disclosure; (b) impact of the abuse. This analysis provides us with a needed context for framing the process of intervention, ie. an understanding of the depth of the effects of victimization; and (c) therapy and healing. Adult survivors' accounts of their recovery process could offer useful insights into important ingredients of the healing process for children, as well as providing information on what survivors themselves need. The methods of analysis were comparable to those used with children and families without the specific focus on the victimization and support theme.

(2) Content analyses. Adult survivors were regarded as important key informants about children and were asked a series of questions concerning their perspective on what is problematic for children during the process of intervention, what children need at different stages in the process, on advice to children and counsellors, and on what survivors require to recover. These 14 questions were analyzed using the content analysis methods described above.

IV.4 THE IMPACT OF CHILD SEXUAL ABUSE:

> ***No one understands the loss and grief you go through. Even my daughter sees it. When she sees pictures of herself before the abuse, smiling, she asks, "What happened to Katie? Where did she go."***
>
> The mother of Katie, abused
> by her father at age 4

Child sexual abuse is a problem with profound immediate and long term effects on the lives of children. Understanding the sources of all the distress that comes into the lives of these children seems complex. It is important to consider a variety of preabuse factors related to the child, her family and the community. Secondly, the nature of the abuse itself, its severity, intrusiveness, duration, the child's age at the time and the relationship to the perpetrator need to be taken into account. And following disclosure, this very private distress becomes a public event, that often radically alters the nature and substance of her life. An extensive and often bewildering array of professionals may enter her life, sometimes with considerable insistence, in an effort to help her in terms of their prescribed and possibly conflicting mandates and messages. While profound effects from the experience of child sexual abuse might not be inevitable, they seem to be quite likely.

> ***A few children may remain "intact", but they are the ones who've had a number of positive, supportive experiences, who are fairly healthy people in the first place. Generally, the whole self can get drawn into it, especially if it's intrusive and coercive. And the system can hurt them too."***
>
> A therapist

The major focus of this study is on the intervention experiences and needs of children and families where sexual abuse has occurred. It is important to begin such a discussion with a consideration of the impact that abuse has on the lives of girls and boys who grow to be women and men. In order to reduce the stressful nature of our interviews, children and families were not asked directly about the abuse experiences. A useful perspective on the impact of abuse also comes from the eight therapists who work most closely with this problem in the province. However, the major source of learning and insight into the far reaching effects of abuse comes from interviews with adult survivors. They told the stories of their sexual abuse and how it has affected their lives as a means of contributing to creating a more helpful intervention system for other abused children.

Seriousness of the problem - therapists' views. Our sample of therapists reflected considerable agreement in response to two "attitude" questions about sexual abuse. All but one strongly disagreed with the statement, "These days, people seem to be making too much out of the impact of child sexual abuse", and all but three strongly agreed that "Child sexual abuse is one of the most important sources of serious psychological problems". Therapists working with a variety of difficult clinical problems saw sexual abuse as having a direct etiological role in their development. ***"A lot of adult survivors are really damaged people. Now we know what's caused a lot of their depression, suicidal behaviour, and addictions ."*** Other therapists identified sexual abuse as very common in suicidal teenagers and adults they work with, and as a "root cause" in other clinical problems like bulimia and anorexia, where close to 75% of those women in group treatment reported a child or adult sexual assault. One therapist did dissent somewhat from this perspective, and felt that it ***"gets exaggerated, and faddish. People are assuming that sexual abuse always has this big impact and it doesn't. You have to differentiate between different kinds of cases."***

Many of these therapists, then, see the immediate attention to child victims of sexual abuse as being preventative in nature. ***"After working with adult survivors, I know the long term effects. You have to work with kids to prevent these horrible problems."*** Indeed, a number of therapists' motivation in their work has to do with stopping the damage they see in their adult clients from occurring. ***"By the time they're adults, they have accumulated so many scars that there's just a whole plateload of issues to deal with."***

Data from an informal survey conducted in 1990 support the therapists' perspective of the centralness of child sexual abuse to other clinical problems. Approximately 30% of adult female clients at community mental health clinics had histories of sexual abuse. Comparable results were obtained in a survey of therapists in the current study discussed later. Therapists are finding that many clients now seek therapy as a means of resolving their abusive experiences, and that abuse issues emerge much more quickly when clients present themselves for therapy with other clinical problems. The local Rape and Sexual Assault Centre now employs a counsellor full time to treat adult survivors, and a related organization is developing a house to provide a safe and supportive atmosphere for women to recover from abuse.

IV.5 IMPACT - THE EXPERIENCE OF ADULT SURVIVORS:

I will be affected forever

Jessica, age 41

It has a tremendous impact. Everything
I am relates to being abused.

Laura, age 32

The narratives of the adult survivors we interviewed repeatedly reflected the depth and breadth of the impact of child sexual abuse. Many feel that it has effected every aspect of their lives, and the sense communicated is of a disturbance at the very center of one's life. Perhaps this is the core of isolation and self protection that survivors must develop to cope with their abuse. But as a consequence, the disturbances in the social, emotional, psychological, interpersonal and sexual aspects of life are very evident in our sample of respondents.

Those we interviewed rated the impact of the abuse on their lives as between "moderately and extremely negative", and many have had multiple problems to confront in their lives.

> ***I lost my self-esteem and self confidence. I was depressed, suicidal and fearful of the future. It has affected all aspects of my life. I felt as if I needed to punish myself with men who would abuse me.***
>
> Lynn, age 35

Other respondents in our sample also had histories of suicide attempts and self destructive behaviour, including eating disorders, and extensive drug and alcohol use. For some women, like Lynn, their victimization continued into their adulthood.

The sense of emotional self protectiveness children required to cope with their abuse often left them feeling fragmented, and separated from others:

> ***I lived two lives with friends. I pretended innocence with them. I kept my distance. I coped by living in a dream world. I never really participated in life.***
>
> ***I was two people, happy at school, miserable at home.***
>
> Vicky, age 39

The wariness toward others, and the need to protect oneself appears to profoundly disrupt the relationships they were able to establish with other people. Difficulties with trust were a key theme in survivors' lives.

> ***It tore me apart. I have problems approaching anyone. I put up a protective guard. I listen to every word and analyze it.***
>
> Joan, age 34

> ***I had poor relationships with no intimacy.***
>
> Sharon, age 30

Relationships with both women and men may become very problematic, and sexual relationships are understandably affected as well. One respondent reported that she ***"used to feel like she was being attacked or used,"*** and sex becomes something to endure with little pleasure :***"my body was dead, my mind was somewhere else."*** Developing nurturant relationships with others is also made more difficult by the need to block off the experience of emotions to reduce one's vulnerability:

> ***I spent the first 34 years of my life without feeling...the only emotion I ever showed was anger.***
>
> Megan, age 37

The struggle with disturbances in self concept are frequent among our respondents, and many report low self esteem, and feelings of despair and hopelessness:

> ***I don't care about anything. It made me into a vegetable.***
>
> Jason, age 27

> ***Being sexually abused made me hopeless, extremely lonely, [I] felt different and feel that I have nothing to offer to anyone.***
>
> Vera, age 41

This very selective discussion of some of the effects of child sexual abuse on the lives of our adult respondents illustrates how profound and lasting the impact of abuse can be. As we encounter the experiences and voices of children in the intervention system and try to develop ideas about how to respond to their needs more effectively, it is important to remain mindful of how deeply wounding abuse can be. Many of these adult survivors whose words appear above have struggled with considerable pain and now feel they are moving toward recovery. But ***"recovery, once you get a handle on it, can go on forever"***.

Perhaps by immediately and sensitively addressing the needs of children who have been abused , they can avoid many of the difficulties that those who have had to maintain silence have encountered. Adult survivors feel a loss of some part of their childhood that hopefully, these children will be able to more readily recover;

Part of you is taken away and you never will know what it would be like not to be abused.

Barbara, age 41

IV.6 THE EXPERIENCE OF CHILDREN:

The major purpose of this study is to identify children's needs in intervention. A major source of the evidence of such needs are problems that clients experience. In the discussion that follows, we have tried to identify those problems wherever they exist. Above all, intervention should do no harm to the victims that encounter it. It is important to be mindful that it is the abuse of power by others, and our legal mandate that requires reporting and investigation that brings these children to our attention. Any problem that children and their families report, or any experience that leaves them feeling frightened, powerless, blamed or betrayed is worth our serious attention. Such problematic experiences demonstrate need, and through the discussion of the experiences and perspectives of all of the children, families and other respondents consulted in this study, we hope to demonstrate the depth and extent of the need as well.

It needs to be emphasized that this study is not an evaluation of the "intervention system" simply because there is no systematic and integrated approach to responding to sexual abuse on Prince Edward Island at present nor is the sample intended to be "representative" of the experiences and concerns of all victims. Our orientation is principally toward problem identification as a means of generating a model for such a system of services. There is a great deal of excellent work being done with children and their families in the intervention system, and such supportive experiences will be discussed in the context of the report findings. But since this is not an evaluation, our aim is not to present a "balanced" view, but rather to identify problems where they exist, since such problems are a reflection of need.

In the discussion that follows, we have tried to "tell the stories" of these children and parents as faithfully as possible. Their names have, of course, been changed. The words, however, are their own.

IV.7 DISCLOSURE: THE EXPERIENCE OF CHILDREN:

> ***I told [my guidance counsellor] a few days after it happened. I knew she would help in any way. She acted serious. She believed me. I felt frightened. Because if he was kicking around and someone told Dad, he would get into a fight. I needed someone to talk to about it. I wanted to get help. I wanted to tell friends but they would tell other people. I was worried that if he found out, he might hurt me because he said not to tell.***
>
> Jennifer, age 9

> ***It's hard because they fear if they disclose it will have to be reported to the authorities. They fear that there will be no safe place for them if they do disclose.***
>
> The mother of Tara, age 15

> ***I don't know if you can ever educate kids enough to get them to trust adults to tell them. I don't know if adults will ever be able to let their kids know that it's OK to tell them about sexual abuse.***
>
> The mother of Cheryl, age 10

The disclosure of sexual abuse makes one of the most personal and private aspects of life a public event. This appears to be a very difficult step for victims to take, and given the estimates of prevalence of sexual abuse in children's lives (e.g. Badgley, 1984; Bagley, 1986), it is evident that most children either don't tell or aren't heard, and that the large majority of cases go undetected (Russell, 1986). It is not uncommon for children to recant their initial disclosures and "accommodate" to the sexual abuse (Summit, 1985), perhaps as a reflection of their understanding of the profound impact that breaking the silence will have on their lives and their families. They may have tested the waters and found them unsafe.

The disclosure of sexual abuse poses a terrible dilemma for children. Above all, they want the abuse to end, but they also fear a variety of consequences for themselves, their families and the offender. They worry about not being believed, and about being blamed, especially if the abuse has occurred repeatedly as is usually the case. In our interview sample, the average duration of abuse was approximately 20 months; in the past case records, the average number of incidents was 25.1. In order for children to find the protection and safety they require, they must risk whatever safety and security they currently have. They may also have a sense of the considerable disruptiveness of the intervention process. To seek safety, they must risk unpredictability. As with the abuse itself, they must bear the burden of a responsibility that children should not have to carry. And they must face this dilemma often with their own sense of uncertainty about whether what the offender is doing to them is even wrong in the context of a society that gives so many mixed messages about sexuality and educates its children so little about sexual abuse. It must be a frightening and lonely experience for a small child.

It is important then, to recognize the complexity of disclosure as a process for the child in order to more clearly identify the needs that children have at this time and to develop means of addressing those needs. In this section, we will first present data on several factors associated with the period before disclosure (previous disclosures and communications, fears about disclosure), followed by a discussion of key aspects of the disclosure process itself (stimuli for disclosure, sources and timing, reactions of others, personal feelings, contexts for disclosure). Finally, perspectives and advice from children, survivors, and mothers about how to make the process easier and safer for children will be presented. Throughout this discussion, it is important to focus attention on how children's needs for safety are met during this process, the degree of support provided to them, and their experiences of control and powerlessness.

IV.8 PREDISCLOSURE.

Previous disclosures and communications. Considering the duration of abuse of children in the interview sample, it is evident that many carried the burden of the silence for a very long time. Only two of the 13 interviewed children (15.3%)immediately disclosed after a single abusive experience. Six of the children in the total sample (20%) had directly told of their abuse on a previous occasion and had their experience minimized, normalized or dismissed. On three occasions, mothers were told before, and one sibling and one friend were also told. The experience of Jane, age 15, reflects a profound failure to protect a child:

> ***Jane's mother informed a counsellor (who one family member had previously seen) of her daughter's disclosure of the father's abuse. The counsellor minimized the abuse as "fantasies the husband could control", failed to report the abuse, and did not support Jane's mother in reporting. The mother, herself, reported after 3 1/2 months and describes her experience.***
>
> ***"I felt sick. The workers made me feel guilty for not reporting. I cried when I talked about my feelings about my husband. Their attitude was condescending".***

This counsellor's professional failure had a profound effect on the family that Jane herself describes rather pointedly. ***"The first [counsellor] was an idiot; he said dad would get better in a few weeks. He screwed us all up. Of everything, he hurt me the most."***

Although only a minority of the children directly disclosed, it was evident that most of the children we interviewed had thought about telling someone but were just too frightened or mistrustful.

> ***I wanted to, but I was scared.***
> ***Once, I was just about to tell my Grade 6***
> ***teacher but I was scared he'd do the same thing.***
>
> Kelly, age 18

The children also appeared to find other ways of expressing their distress about the sexual abuse and trying to draw attention to it. Forty percent (40%) of the mothers reported that they felt the victim was exhibiting signs prior to disclosure, and in some cases, mothers pursued their concerns quite vigorously.

> ***"I had been breaking the law and running away***
> ***from home. My mother pressured me into***
> ***telling what was wrong, and I couldn't come***
> ***up with another explanation"***
>
> Bob, age 15.

Almost all of the adult survivors in our sample (95%) felt that children do disclose in ways that adults don't see, and that they communicated their abuse through various forms of behaviour:

(a) withdrawal - e.g. moodiness, avoidance, fear of adult touch, personality changes;
(b) acting out - e.g. drug use, self-destructive behaviour, delinquency, aggressive behaviour, eating disorders;
(c) play.

Most (69%) of the children we interviewed also felt that they were communicating their abuse through their behaviour in various ways .

> ***I would cry at night before going to sleep***
>
> ***I tried to give small hints to mom."What***
> ***time do you go to work? I hate when you***
> ***work 6 to 2"***
>
> ***I used to be a little mean to other kids.***
> ***I didn't have any friends.***

As one survivor said, ***"I tried to tell in a lot of ways"***, but the ways, of course are not always consistent, or clear to adults. Another expresses it this way: ***"Some may act out, some just blend in."***

It appears that children may be disclosing their abuse considerably more than adults think, but that their means of communication might be quite different from the language we expect and attend to. While we might encourage children to disclose more directly, we should place equal or more attention on listening to children's language and teaching adults to understand the various ways they do make their abuse known.

> ***I tried to spell out the words to [my guidance counsellor] because it was hard to say the words.***
>
> Jennifer, age 9

Fears about disclosure: Children remain silent about sexual abuse for many reasons, and this silence then comes to contribute to the devastating effects of the abuse, since the child's willingness to keep the secret draws her into the cycle of self blame which then makes disclosure still more difficult. Adult survivors identified a number of reasons why children don't disclose their abuse that reflect the following themes.

(1) Fear of safety . It is very common for children to experience physical threats and assaults in relation to their abuse, so they understandably come to fear future retaliation from offenders. Analyses of case records of past and present social services cases indicated that in 44% and 60% respectively, there was some form of violent act or threat present. Within our sample of children interviewed, 61.5% reported a fear of violence as factor in maintaining their silence. The threat was often quite explicit.

> ***My step-father was temperamental. He said, "I'll kill you if you tell. Your mother will never believe you.***
>
> Cindy, age 16

> ***I had been scared to tell because the guy said he would throw me off the wharf and I can't swim.***
>
> Jim, age 13

Sometimes, the threat to the child is more symbolic and "age appropriate".

> ***He said he would hurt my hamsters, he said that all the time and he scared the hamsters.***
>
> Julie, age 7

(2) Fear of disbelief. Children fear that no one will believe them when they disclose. In the case of Lisa, age 12, her parents were supportive when they learned of her abuse by an uncle, but when they subsequently learned of another assault by a camp counsellor, they were unable to accept it.

> ***My husband and I were devastated. We couldn't believe that it could happen again. We blamed her for [________________].***

One therapist noted that even professionals might have trouble being receptive to more uncommon forms of abuse (e.g. ritual abuse, female perpetrators).

(3) Fear of consequences. Children are particularly concerned about the reactions of their families and the consequences for their families. Katie (age 9) was worried her dad would come to get her and Sheila (age 15) was worried about having to go to court. Kelly (age 18) said:

> ***I was scared of being beaten and losing my friends if I told. Your only friend is the person doing it to you; he wants to be closer to you. I was afraid they would lock him up forever. I wanted that and didn't want that.***

Children's fears are sometimes quite well founded. In Kelly's case,

> ***Telling just made things worse. I lost my home, friends and family because he wouldn't leave.***

As Jane's mother put it, ***"they need to be able to tell without disruption of the family and having their world blown apart."***

(4) Confusion about abuse or who/how to tell. Several children in our sample indicated that they didn't know that what was happening was wrong. Children may either lack knowledge, sense that sexual abuse is not something that you talk about, or not know who to approach or who to trust with their disclosure.

(5) Self blame. Children may feel implicated in the blame for the abuse, feel humiliated about what has happened or fear that they have done something wrong.

Factors contributing to disclosure. It is perhaps easier to understand the considerable obstacles to disclosure than to gain insight into how children come to decide to disclose. For a number of our respondents, disclosure appeared to be more of an opportunity that presented itself rather than a deliberate choice. Children may disclose in response to a mother or aunt's inquiry into behavioral signs or in response to an inquiry from a neighbour whose son has been abused. Within our sample, it appears that public awareness and education campaigns also presented useful "stimuli for disclosure".

> ***I was watching "Something about Amelia" on TV when I realized it wasn't normal. Jackie and I looked at each other and I realized that it had happened to her too.***
>
> Kelly, age 18

> ***People came to my school to talk about sexual abuse and I just couldn't keep it a secret anymore.***
>
> Katie, age 9

Anne, age 2 1/2 disclosed to her mother after watching "Mr. Dressup" on television, while 12 year old Lisa cited "education and TV" as factors in her disclosure. There are some children, like 14 year old Kathy, who really think about disclosing the abuse and make a decision about it.

> ***Coming home from ______ where I was visiting my father,***
> ***I thought about it [the abuse] on the plane and knew it was wrong.***
> ***I told my mother and her boyfriend right away.***

For others the emergence of the secret is much more spontaneous and "opportunistic". It is very important to recognize that there are multiple pathways to disclosure, and to provide increased opportunities that emotionally initiate the topic with children.

IV.9 DISCLOSURE:.

> ***I told Miss T., the guidance counsellor at school. It was getting on my nerves and I knew I had to tell someone. I thought she would be the right person. She told me I could come to see her then and for a long time - even next year if I wanted to.***
>
> Mary, age 7

Source. Within our interview sample, children most frequently disclosed to family members. Mothers were the most frequently chosen persons (58.6%) and some disclosed to other relatives (13.7%). A number of victims choose to first tell their friends (17.2%), while only 6.9% chose school guidance counsellors to receive their disclosure. There appears to be somewhat more parental disclosure within our sample than in the past CFS cases, and somewhat less disclosure to school counsellors . In the four years of records examined, only one physician received and reported a disclosure of sexual abuse.

Reactions. In our interview sample of children, the act of disclosure is as likely to be accompanied by continued fear and worry as it is by a sense of relief and safety. In our study, comparable numbers of children's reactions can be classed as relief (33.3%), fear (33.3%) or a combination of these emotions (33.3%).

> ***After I told my mom and the police, I was afraid that my father would come and take me away. I'm not afraid of that anymore, but I'm just afraid of everything, all the time. I can't sleep good at night and I have nightmares.***
>
> Katie, age 9

Generally, the reaction to the initial disclosure is very favourable and supportive.(***"She acted serious. She believed me"***), and only two of the 13 children interviewed experienced an ambivalent reaction. Most commonly, the person to whom the child discloses shows understanding toward the victim and reacts with some shock and anger toward the offender.

Families: The response to disclosures within families represents a critical factor in children's process of recovery from sexual abuse, and mother's reactions have been identified as central to this process. Within their families, children indicate that they received strong maternal support in most cases (66.7%), with more ambivalent responses sometimes occurring (16.7%), as well very negative and destructive responses (16.7%). Other sources of data also indicate that maternal supportiveness is usually present at disclosure. In 75.1% of current cases, mothers were rated as responding in a "generally" to "highly" supportive way by social workers. But the absence of a supportive maternal response in the cases where it does not occur represents a significant betrayal.

> ***At first my mother believed me. When she got home, she changed her mind. He overrules her. She didn't believe me anymore. My mother wouldn't speak to me.***
>
> Cindy, age 16

Most of the time, this ambivalent reaction occurs in situations where fathers or stepfathers are the perpetrators. Mothers, themselves often unsupported and the victims of physical or sexual abuse, are placed in a situation that one guidance counsellor labelled as a "Sophie's choice" between their child and husband. While some, like Cindy's mother, seem to ally strongly with the father, others are clearly torn between their desire to protect their child and their needs for their partner.

> ***I was shocked and murderous. I wanted to protect Jane, but I didn't want my husband to go to jail. I wanted him to get help, to get therapy for both of them.***

Sometimes, even when perpetrators are not husbands, mothers may find it difficult to support their daughters.

> ***She was angry at me for not telling sooner. She found it hard to believe because he was so wonderful to her. She was really close to my brother-in-law. Its hard to know how she feels. She chooses to brush it off. She doesn't want to let it out of the family. She is religious and thinks you just pray and God will take it all away.***
>
> Sue, age 18

Patsy's mother was disappointed and angry with her daughter who disclosed abuse by her grandfather when she was 11. She was caught in the dilemma of reporting her own father, and struggling with her feelings of failing to protect her daughter, especially given the fact that her father had previously abused an older daughter.

It is apparent that mothers' needs must be understood far better if they are to be helped to providing more safety for their abused daughters and sons. This may not be an easy understanding to achieve. We live in a culture that tends to hold mothers responsible for meeting all of the emotional needs of children, and we tend to blame mothers quite easily for children's problems (Caplan, 1991). Early sexual abuse literature commonly identified mothers as "collusive" in their daughter's abuse, often when they abandoned their traditional roles to seek more for themselves (Butler, 1985). As we will see, mothers frequently feel blamed, especially in the process of investigation, for a failure to protect their children. It is worth remembering that the issue of fathers' failure to protect their children when abuse occurs is never even raised. One therapist identified the most difficult aspect of her work as dealing with mothers' ambivalence. ***"Given the choice between the abuser and the child, they may choose the abuser. I can't understand how they could do that. It really upsets me."*** Hopefully, when we can better understand the mothers' experiences in this dilemma, we will be able to empower them to provide the safety and support their children need.

Fathers seem to be rarely involved in direct disclosures, but where they are not offenders, they are rated as responding supportively to disclosure in most cases (72.1%) by social workers. Siblings appear to experience more conflict in their reactions, particularly to paternal disclosures of abuse. Like mothers, they must choose between supporting their sister or brother, or confronting an awful truth about their parent. In Cindy's family,

> ***My older sister believes me and talks to me. My younger one doesn't.***

Siblings must struggle with this dilemma, and are often slow to support the victim. Kelly noted,

> ***They seemed to believe me and not believe me at the same time because they idolized my father.***

Their own fears about victimization may be touched off as were Jennifer's sisters, or one child's disclosure may bring forth disclosures from other siblings. In some of the families interviewed, where there was more than one victim, such "multiple disclosures" occurred.

As the reality of the abuse settles in, support is far from assured for children in their families. When asked to describe their feelings within their families in the month following disclosure, equal numbers (42%) endorsed exclusively or predominantly negative adjectives related to support/victimization (e.g. different, ashamed, guilty, helpless), and positive experiences (e.g. feeling supported, believed, cared for, understood). The rest had more mixed feelings in their families. Kelly describes the crisis atmosphere succinctly; ***"Everything was in an uproar."***

Outside the family: Where children told friends about their abuse (and several of our interviewees did not), they generally responded in a positive fashion, sometimes, dramatically so.

> ***He came to a dance looking for me. He said he came to kill me. I went to a back door and all my friends came around me and wouldn't let him touch me.***
>
> Cindy, age 16

Cindy also comments on how difficult it is when the child's life becomes so public as people in the community learn about the abuse.

> ***It's like they knew something about me that I never would have wanted them to know. All the teachers knew, so they could protect me. It felt really uncomfortable knowing they knew.***

The reaction of school personnel is of particular relevance to a discussion of community reactions. As was discussed, school counsellors are themselves a major source of disclosures, and at least several respondents report very positive experiences with their counsellors. Given the involvement of schools in the daily lives of all children, they are often mentioned as a means of "opening up disclosure pathways". The data from our interviews provides a mixed picture of the kind of atmosphere for disclosure that the "front-line workers" in schools, ie. teachers, present to students.

> ***My guidance counsellor told my teacher and my teacher made me tell another teacher to their face. They just stared at me and nearly made me cry. I never knew they were going to tell.***
>
> Jennifer, age 9

Jane, age 15, did not feel that teachers were understanding of how hard it was for her to concentrate on school during the time after the disclosure.

> ***"Teachers need to know how it feels to be sexually abused and what happens to families so that they can help kids get through school. Kids shouldn't have to fail a grade."***

A more through discussion of the schools role in sexual abuse is presented later in the report section on "Community".

Occasionally, the possibility of a disclosure will emerge in the context of therapy for other problems. This represents a rather unique situation for the child. While children seem to benefit from the presentation of a variety of opportunities for disclosure, they also seem to need some sense of control over the process. Generally, children can seek out (or avoid) disclosure sources, or respond to (or evade) the questions of adults and friends in ways that gives them some control over initiating the process. Within therapy, however, where the discussion canters on the child's problems and concerns, such "negotiation" of disclosure timing is somewhat more difficult. Therapists, like others, are required to report abuse, and children appear to be aware of that. If children do not feel ready and safe in reporting, they may leave therapy, be less able to trust the therapist, or try to develop ways of having some control. Some children are reported as leaving therapy rather than disclosing. Another therapist felt that mandatory reporting ***"shuts them up. I think we'd hear a lot more [if we had some choice]."*** Children may discuss the abuse hypothetically ("I've got a friend who..."), or manage the information given to therapists to avoid putting them in dilemmas where they must act in ways that the child perceives as being counterproductive to her therapeutic interests.

Therapists develop a variety of means of negotiating disclosures to try to deal with this dilemma. Some now have informal relationships with individual protection workers, where they or the child can call to get information and discuss options. One therapist will only immediately report if there are imminent safety and reabuse issues, because ***"I want her to have some measure of control."*** She told the story of a very passive 15 year old girl who was given the weekend to decide how she and her therapist would report to Social Services. In that time, the victim confronted all five of her abusers, telling them that she would report any of them that ever touched her again. Her ability to act so assertively to maintain her own safety contributed to a major change in attitude and demeanour and reflected very significant therapeutic progress. While others must continue to have the responsibility to act in ways that assure children's safety, these experiences and reflections strongly suggest that children's needs for safety must be balanced with their need to maintain some control over the timing and nature of the disclosure process. To assure this balance, it would seem useful to provide therapists more "formal flexibility" in reporting. It is very important to keep the child-centred goals of such a suggestion in focus so that abuse is not minimized or disclosure discouraged based upon criteria that have nothing to do with children's needs for control or safety (e.g. as we saw above in Jane's case).

Reporting. Generally, those who received the disclosure reported the abuse quite immediately if they were supportive of the victim. This is a tenuous time for children, as we shall see when speed of investigation is discussed. Kelly was confused and upset by the delay in response after disclosing to her aunt. Sometimes, supportive parents may try to manage and control the abuse themselves, like the parents of 7 year old Mary and her sister who were abused by their cousins.

> ***We tried talking to the boys and giving them information on sexuality. We also tried intimidating them when that didn't work. After this, the sexual activity stopped for six months, then reappeared, but the girls didn't disclose.***

Parents are generally knowledgeable about where to report the abuse, and most contact either Social Services (40%) or the police (36%). A substantial number will contact other agencies, such as the Rape and Sexual Assault Center who will refer them on. One mother did not know where to report, and told of the frustrating experience of making a number of phone calls to find the right office.

IV.10 DISCLOSURE: AN OVERVIEW: Children are encouraged to disclose their sexual abuse so that they can obtain safety and protection. While an overall assessment of how successfully children's needs for safety are met requires a broader analysis of the complete intervention process, it is important to evaluate whether children obtain immediate safety in their lives when they disclose. The following experiences raise some serious concerns about how well promise of safety offered to children is actually provided.

> ***Jane disclosed her father's abuse to her mother, who reported it to a counsellor who minimized it as fantasies the father could easily control and didn't support mother's reporting of the abuse. It was 3 1/2 months before the abuse was reported again, this time to Social Services.***
>
> ***In Cindy's case, her father threatened to kill her, and no charges could be laid because a witness was too frightened to testify.***
>
> ***Everyday when I walk to school, he [the perpetrator] scares me by making faces in the window.***
>
> Jennifer, age 9
>
> ***The mother of Julie, who disclosed her brother's abuse at age 5 1/2, wishes that her son could have been removed to a group home earlier than he was.***
>
> ***After disclosing, I got phone calls from my father saying gross things.***
>
> Kathy, age 14

And if a sense of predictability and certainty and a return to a relatively normal life are relevant to the experience of safety, then Judy's story should be mentioned.

> ***When she was 9, Judy was fondled by a neighbour. While the abuse frightened her, it was of short duration in her life. The court process was extremely lengthy, and the offenders initial conviction was appealed and a new trial ordered.***
>
> ***Now, more than two years later, Judy had trouble remembering the details of the abuse and the Crown dropped the case. During all this time, "she was trying to go to school and keep it out of her mind".***

Judy's relatively short, although frightening abuse became a major focus for a considerable period of her young life. While the system's response did appear to protect her from the perpetrator, it did not protect her from having the experience of victimization remain as a central feature of her life. In fact, it promoted such an experience. And just as Judy may have blamed herself for the abuse, as victims so frequently do, ***"she thought it was her fault that it couldn't be taken back to court"***.

IV.11 DISCLOSURE: PERSPECTIVES AND SUGGESTIONS:

There has been a decade of considerably more public discussion of sexual abuse, and one would hope that such increased attention would contribute to a more supportive atmosphere for disclosure for children. When adult survivors were asked if it was safer to disclose now compared to how it was for them, 70% felt it was, while 30% felt it was not. One therapist felt that there is still a great deal of mistrust of children when they disclose.

> ***We still have to think that kids might be lying. In investigation, intervention, court, it doesn't start from a premise of belief.***

This therapist felt that after a period of somewhat greater openness, children might be "closing down" again, and be less willing to risk disclosure.

Children, mothers and adult survivors were asked their advice on what would make it easier for children to disclose sexual abuse, and were in basic agreement about the factors that would make a substantial difference. The suggestions of all respondents in these groups are presented in their entirety in the Appendix. The children's suggestions revolved around the following themes:

(1) Reassurance of safety and belief. There needs to be an atmosphere of emotional safety for children. They need to feel believed and trusted, be approached on their own level, and given opportunities to speak with someone who will truly listen to them and protect them.

> ***If adults would tell kids that its OK and that they don't have to be afraid. Reassure them that nothing will happen and its OK to show their feelings. If they don't tell they will always think they're dirty and will be too afraid to go out into the world. They have to be reassured that people care and want to help them and if they get that help they'll be able to make it in the world.***
>
> Kathy, age 14

(2) Openness with parents. In particular parents were seen as key persons for safer disclosure. More and better communication, parental initiation of the abuse topic, and a more open family atmosphere free of blame were seen as key ingredients of greater openness.

> ***Parents should always be open with kids, encourage them to tell and trust them.***
>
> Jane, age 15

(3) Education for children. This was mentioned frequently among all of our informants, and included education in normal and healthy patterns of sexuality, as well as in recognizing abuse, and what to do to avoid it or to report it.

> ***It's important to educate kids early about sex. Its important to let kids know what's happening with their bodies. You can't leave responsibility just on the parents.***
>
> Sue, age 18

> ***A guidance counsellor read a book to our class [about child sexual abuse]. I remember that it helped.***
>
> Mary, age 7

> ***Talking to other victims..kids like me going to school.***
>
> Kelly, age 18

(4) Education for others. Children were concerned that parents and teachers know more about sexual abuse, how to recognize it, its impact upon children's emotions and behaviour, and to learn how it feels to be abused. Adult survivors also highlighted the importance of more public education not only of signs and dynamics, but to address the social attitudes that contribute to sexual abuse.

(5) Safer pathways for disclosure. Children also thought about the people they would talk with in disclosure and as they recalled investigation, and Kelly noted that

> ***Girls might be afraid to talk to adult males.***

Mothers were asked how victims and families could be assisted in the reporting of sexual abuse, and many of their comments reinforce the children's suggestions, and are pertinent to the investigation processes as well. They emphasized need for (a) a more sensitive, less intrusive and child-centred response to ***"ensure that people are treated with***

the utmost dignity and respect"; (b) having fewer people involved; and (c) an awareness and assurance of sources of support.

> ***A lot of people don't know that there are places like Anderson House and that if they have to leave their husband, they will be supported by social assistance and that it is OK and acceptable.***
>
> ***People on social assistance have a fear of the system and may be reluctant to report. People may feel they won't get the help they need.***

The disclosure process is extremely complex and frightening for children. They must risk a good deal of their present security in making their private abuse a public fact. Given the nature of responses to their disclosure in their families, schools, communities and in the intervention system, the promise of safety and protection offered to them is often not fulfilled. Perhaps the advice that children, families and adult survivors offer is not unfamiliar to those who respond to sexual abuse. While the initial responses to disclosure appear to be fairly supportive to children, there appears to be significant work to assure that a sense of safety (with some control) will be available to them in other contexts. And until this safety is present, children will rightly view the possibility of disclosure with considerable apprehension. It is worthwhile to remember Kelly's words about this to keep the dilemma children face clearly in mind: ***"Telling just made things worse."***

IV.12 INVESTIGATION: THE EXPERIENCE OF CHILDREN:

> ***I was really confused and scared. The two way glass was scary - people might have been watching me. They make you be extremely specific. That's OK, as long as they explain what the words mean. I guess the social workers and the police believed me but they weren't very comforting. I didn't want a man there. They didn't tell me what was going on - about that Dad might go to jail. I didn't like having to say things over and over again. Mom was pretty good. She told me to say everything. When I forgot something, I got more confused. I felt they had to dig things out of me.***
>
> Jane, age 15
>
> ***I don't think there's any way of making it easier.***
>
> Sue, age 18

Once the child's disclosure of sexual abuse is reported to the agency (or agencies) with the responsibility for legally responding to it, the formal process of intervention begins. Not only is the child's private pain now a public fact, but it now becomes the "business" of other people. It is their job to inquire into it, assess its validity, evaluate its quality in relation to a child's need for protection or other social services, determine its legal substantiveness in order to decide about the laying of charges, offer the child assistance if such charges are laid, prepare her for the court process to adjudicate these charges and engage her in therapeutic encounters to help her recover from the trauma of her victimization.

The change in the child's experience after disclosure is profound, and few appear to be prepared for what follows. As we have seen, children fear the consequences in the disruption of their lives if they disclose. They also may have ideas and fears about what might happen to the perpetrator who may be a loved and important person in their lives, or about appearing in court. But they cannot possibly know how breaking the silence about their abuse will involve them with so many people who work in so many different agencies, often with different and potentially conflicting mandates and responsibilities, all of whom, in their own ways, are trying to help this one hurt and vulnerable child.

This complex process of intervention begins with the investigation of the disclosure. The aim of this section is to describe the child's experience of the investigative process, with particular attention to the problems they encounter with it and the needs they have. Most specifically, we want to identify the sources of victimization and support associated with the investigative process to provide guidance in what elements to include and avoid in the development of future services. Given the traumagenic dynamics of victimization discussed earlier, several key needs of sexually abused children would seem important to address in intervention. (1) A sense of **safety** would seem to be a prerequisite for recovery, a basis for any therapeutic relationship, and a central means of addressing the sense of betrayal that victims so commonly experience; (2) A sense of **support** from others helps to provide the understanding, caring, validation and acceptance that helps to address the feelings of shame, blame and isolation associated with stigmatization; and (3) a sense of **control** over what happens in one's life seems essential to address the feelings of powerlessness of being a victim, and of beginning the process of living life on one's own terms. To the extent that encounters with persons and structures in investigation and other aspects of intervention provide safety, support and control, they provide the basis for healing and recovery. To the extent that these key experiential ingredients are absent, the child's feelings associated with her sexual victimization are reinforced. This is what we mean by revictimization.

> ***You have to realize that you are dealing with the most scared children in society.***
>
> An adult survivor's
> "advice to helpers"

Sexually abused children always seem to have lived in an adult world, and many of the survivors we interviewed and others (Danica, 1989; Women's Research Group, 1989) speak eloquently about the losses of their childhoods . The world of intervention is another part of that adult world that children must traverse, and they begin this journey with considerable fear of the consequences of their disclosures. As adults, it is difficult to appreciate how foreign this territory must look to children, and how frightening it is.

> ***Jason didn't know what was going on. He wouldn't talk about what happened. He wanted to go home. I wasn't allowed in the room with him. They were very good to him, but he wasn't in the right mood to talk. He might have cooperated a little better if he had met the investigators before.***
>
> The mother of Jason, age 4

> ***The most upsetting part was when they were asking me all those questions. They explained things, but in a weird way.***
>
> Jennifer, age 9

For the process of investigation to be supportive to children and avoid their revictimization, it must carry out its adult mandates in ways that are always sensitive of the needs and developmental level of children. This is a formidable task, and not always successfully done.

The investigative process appears to almost always be difficult for children. Among the children interviewed, 72% found the investigation to be upsetting, and 54% endorse predominantly or exclusively negative adjectives to describe their feelings (most commonly confused, scared and ashamed). The "not upset" children tend to endorse "safe" and "understood" to describe their reactions. When mothers were asked about their perceptions of their child's reaction to the police investigation, 30.4% indicated that the children were "strongly upset", and 31.8% said that the CFS investigation "strongly upset" their children. Sometimes the source of their upset just seems to result from being a child having to participate in an investigation.

> ***Two workers came to school on the same day. It was scary because I had to tell them everything and be very specific. It's hard to talk to strangers about something like that, especially if you're a shy person.***
>
> Cindy, age 16

Sometimes, the sources of upset are more extensive and varied, and are also related to the conduct of the workers involved with the child, and the high potential for intrusiveness in the process.

> ***The police took about 16 statements! Social Services was involved too right away. It was hard to remember all the stuff. The social workers were supportive and understanding. The Police were not sympathetic - they asked personal questions and it didn't take the fizz out of them. They were pumping me for information, they said "you have to remember more." It seemed to get out of my hands. The doctor seemed to be calling me a liar. She seemed not to know a lot about it.***
>
> Susan, age 15

In order to more systematically discuss the sources of children's upset and possible revictimization, we will present problems, concerns and experiences with investigation in terms of the themes of **safety, control and support**, all of which appear to be problematic in the system's response to Susan. There is, of course, considerable overlap among these three themes, but the use of this framework will be helpful in organizing how well different aspects of investigative practice are meeting children's needs.

Safety. In order to have a sense of safety at this point, it is essential that children feel that they are believed, and that the abuse is taken seriously. They need to feel that they are no longer at risk of being abused, and they need others who respond to them to react in ways that will minimize rather than exacerbate the fear they experience at this vulnerable time. This requires considerable sensitivity, and awareness of the need for trustworthiness in interacting with these exploited children. Several particular aspects of investigation reflect problems with providing safety for children.

1. Problems with belief and minimizing. Usually, the investigative process does not raise questions in the minds of children and mothers about whether they are believed or taken seriously. The mother of Jane, age 15 reports how she was helped by the "memory of how the RCMP officer had made her feel like someone to be believed." But sometimes this is not the case. The most striking example of such minimizing came from the Jane's counsellor, mentioned earlier, who "normalized" the abuse as an easily correctible fantasy of the father, and who left her at risk for future abuse for 3 1/2 months until mother reported again, this time to Social Services. Jane's mother's positive feelings about the RCMP officer stand in sharp contrast to her views of the destructive impact of the family counsellor.

In other cases, mothers raise concerns about how the police and Social Services respond to complaints.

> ***The police didn't seem to take us very seriously the second time we reported. The police didn't lay charges even though the uncle admitted he had abused my son's friend.***
>
> The mother of Bob, age 15

> ***They treated me like an alien, and [like] I was wasting their time --like a neurotic mother. They said that they could not investigate because it hadn't happened that day. The child abuse line got the police to investigate.***
>
> The mother of Lori, age 4

> ***Jim was one of a group of boys abused by the same perpetrator. His mother felt there was some disbelief among the police because of the group involved, and because their stories didn't always match.***

The sense of not being believed or taken seriously is one of the most devastating reactions others can make to a disclosure of sexual abuse, since it reinforces the deep fear that victims carry of not being believed, and invalidates their perceptions and distress. We do not, of course, know about the details of the processes of investigation, validation, or the communications that took place from the viewpoint of the workers involved in the cases cited above. What is important here is that in the cases of these three mothers and their children, their experiences with police and Social Services left them feeling unbelieved and unprotected.

Sometimes the respondents identified a risk not just to the children who have been abused but to others as well. Jason, age 4, was molested by his babysitter's husband. His mother was concerned because:

> ***The social worker was supposed to tell other families who were babysat by the same people and they didn't tell them for three weeks after the disclosure. They should have told them sooner.***

(2) Problems with delays, and length. As Jason's mother's story indicates, delays in response to complaints of sexual abuse may work against providing victims, families, and the community with the sense of safety they require and the longer the process goes on, the more the child remains immersed in the adult world where the fact of her abuse remains central to her experience.

Mothers reported that in 36% of the cases, police investigations took place within 24 hours. Forty four percent (44%) occurred within 48 hours and 64% were conducted within a week. Social services' speed of response appears comparable, with 29.2% of cases investigated within one day, 50% within two days and 70.8% within a week.

For children, when there is a delayed response it may also prolong their uncertainty.

> ***The police came in the morning the next day. The police didn't question [Ellen] until several weeks after they talked to us. They should have talked to her about it right away. She worried until they came.***

In Bonnie's case, her mother feels that the investigation of the abuse alleged by a neighbour went on far too long, and that the police waited too long to get the necessary statements to refute the allegation.

Karen and Anne came home with their mother from a three week holiday, only to have to resume the lengthy process of investigation, and Patricia's nine month experience with investigation came to be central feature of her life. Donna's mother recounts her daughter's experience with an investigation that was begun, interrupted and resumed several years later after her daughter attempted suicide. She is upset by how long the whole process takes to finally get resolved in court. Bob's mother sums it up succinctly. ***"The process takes too long. It's hard on the victim to wait."***

(3) Problems with betrayal of trust. Sexual abuse often represents a profound betrayal and exploitation of a trusting relationship, and the consequences of betrayal are reflected in many of the interpersonal problems children and survivors develop (Finkelhor & Browne, 1985). It is therefore disturbing and very problematic when children and their families feel that workers are untrustworthy, as the following cases reflect.

> ***Janet's mother felt that the social workers who interviewed her daughter betrayed her trust. They encouraged her to say things under the guise of confidentiality and then "they used the interview against her and her father. They lied to her."***
>
> ***Lisa told the police about a second assault by a different perpetrator. Her mother comments: "The police lied to her and said they would not tell [her family]. They were nice but breached her trust. They made her tell so they could prosecute and then they didn't. She lost respect for authority."***
>
> ***The social workers told me I could be there if Bonnie wanted and so I told this to Bonnie. They never asked her, and therefore, I looked like a liar.***
>
> ***Jim's mother was upset because police said that they would pick up the offender right away and then they didn't.***

It is useful to note that the first two statements are made by mothers experiencing some conflict and "divided loyalties" in cases of paternal abuse, while the third statement is made by a mother where suspected sibling abuse in her family was reported by a third party and never validated. All three have considerable dissatisfaction with their experiences with several aspects of investigation. But these several experiences also add some additional support to the observation made earlier about problems with sensitive and understanding treatment of mothers who are caught in the dilemma of some ambivalence. Workers may well feel the need to ally with the child and protect her, but when this is done by not being completely straightforward with children and families, the sense of betrayal and bitterness may be profound.

(4) Problems with medical examinations. Within the family interview sample, 42.3% of the children had to undergo medical examinations. Here the possibility for experiences associated with lack of safety and revictimization is high because of the physically intrusive nature of the procedures. The need for a knowledgeable and sensitive response to the victims is essential in this context. In seven of the 11 cases where children had such exams, the experiences were memorable enough to warrant comment. In all but one case, these experiences were negative.

> *When Jim was examined at age 9, "the doctor's visit was OK because he is our family doctor and I like him." However, his mother arranged this exam when the RCMP "didn't do a thorough examination of the physical evidence because he is not a girl."*

The rest of the encounters with medical exams described by respondents span the range from experiences of distress, through perceived physician discomfort and lack of knowledge to profound feelings of revictimization.

> *Mary, age 7, says that "the doctor hurt me and I felt really tense. I would like to have gone to my own girl doctor." Her mother describes the experience of Mary (and another abused daughter) in more detail. "The kids didn't want to go to a doctor they didn't know. When he examined them internally, he didn't wear gloves. He put instruments in them and they weren't expecting that. It was like they were being abused all over again – they felt like they were violated again."*

> *The mother of Tara, age 13, says that the doctor's exam caused her daughter "to lose her virginity. She felt revictimized and felt she had no right to say 'no'. Dr._____ was requested by Social Services. They wanted him to do the whole Rape Kit which was inappropriate. She was more defeated at that time and wondered if she could handle it."*

As reported earlier, Susan felt the doctor was ***"calling me a liar"***, and Cheryl, age 10, ***"was questioned over and over again at the hospital. When the doctor examined her, neither he nor the nurse knew what to do with the Sexual Assault Kit."***

These experiences identify a clear need for training among physicians involved in the response to sexual abuse. Other sources of data also suggest their limited involvement in the sexual abuse problem at this time. As indicated previously, only one report of abuse by a physician was recorded in 4 years of Social Services records. Intake workers also reported an experience of spending all day in an Emergency waiting room with a child waiting for a medical exam as part of the investigation. It is evident that a lack of physician involvement and training represents a major gap in the investigative process.

Control.

Powerlessness is a central ingredient of the victimization experience. Abused children have had to respond to the inappropriate needs of others, often under conditions of duress or implied violence. If victimized deeply enough, they may have come to feel that their own needs and wants are of little importance, especially compared to those of bigger and more powerful people. To be free of the coercive agendas of others, to have control over what happens to you, to be listened to and to have one's wishes respected, (particularly in being able to stop something that you don't like from happening to you) are central aspects of the self-direction that survivors work toward. As one adult survivor commented in her "advice" to abused children;

> ***Eventually we grow into adults and then we can control what we do with our lives and make our own decisions.***

The following aspects of problems, concerns and experiences with investigation appear to be most directly related to children's experiences of control and powerlessness.

1. Pressure. Children may feel under considerable pressure to respond to adult needs of investigators to "produce" statements of sufficient depth and quality so that social or legal intervention is possible. Children are asked, almost immediately, and in a short time span, to describe these personal and painful experiences to a complete stranger.

For Cindy, this rapid immersion into the adult world of investigation upset her "a lot."

> ***They could have given me a bit more time after the disclosure. I didn't like the questions at all. To give your statement for 2 or 3 hours is too hard, when you've just told about the abuse for the first time.***

For some children, dealing with this pressure is simply more than they can handle. The mother of 7 year old Katie reports that the investigation by the police was "strongly upsetting.

> ***She would have felt safer if she could have sat in my lap. She stopped talking and went into her room and hid in a corner for 2 or 3 hours. She wasn't prepared by the police for the investigation. It would have been better to have a female police officer. They put pressure on her by the tone of her voice. It's more like interrogation and it scared her.***

This pressure may be particularly evident in cases where investigators perceive that there is denial, such as the experience of Julie, where alleged abuse was reported by a neighbour. The police interviewed her several times.

> ***Her mother reported "The police badgered Bonnie. She told the truth but they wanted to make a case. Bonnie needed protection from the justice system." Bonnie was "strongly upset" by the investigation. "She refused to go to school, clung to her mother and didn't want to talk to anyone". The investigation process went on for more than two weeks before the case was dropped.***

Susan's experience of the police ***"pumping for information"*** and telling her ***"you have to remember more"*** is also clearly descriptive of what such an experience of pressure is like. Bob felt he ***"had to tell things I didn't want to say."***

Such experiences stand in contrast to that of Donna's mother who reported that the social worker ***"listened to me when I asked her to back off."*** After a difficult experience with the police interview, Katie's mother felt her daughter was

> ***treated with a great deal of respect by [the social worker]. There wasn't any pressure on her to talk.***

And seven year old Mary ***"liked telling"*** her social worker and ***"did not feel like they were forcing me"***.

2. Intrusiveness. For children, sexual abuse has the potential to intrude upon every aspect of their lives, to touch and disturb the most personal and deepest aspects of their experience. Given the sensitive and painful nature of the content of investigation, it is not surprising that the most common source of upset for children in investigation is the

difficulty they have in talking about the abuse experiences. Mother's identified this as source of upset in 38.2% and 26.3% of the Social Services and Police investigations respectively. The nature of the questions asked also upset the children in a substantial number of Social Services (20.6%) and police (15.8%) investigations.

> ***It was confusing and scary because I had to talk about details. It's gross.***
>
> Jim, age 9

> ***The most upsetting part was talking about how he was hurting me.***
>
> Julie, age 7

> ***The most upsetting part was when they were asking me all those questions. They explained things but in a weird way.***
>
> Jennifer, age 9

It is particularly upsetting when the nature of questions contributes to children feeling blamed and responsible for what happened.

> ***Patricia, age 15, was upset by police questions like "did you wear provocative clothing" or "did you do anything to lead him on" in the investigation of abuse by her stepfather. "I was embarrassed and felt blamed. I thought they were trying to see if I was lying."***

It is also evident that children can become easily overwhelmed by the number and intensity of questions (***"I didn't like having to say things over and over again." "They kept pressuring me for times and dates. It was hard."***), and may be confused by them because they are not on their own level, and are difficult to understand.

> ***It was hard to answer yes or no because the answers were sometimes in between.***
>
> Mary, age 7

Sometimes, it may take children some time to clearly realize the purpose of the investigative questions.

> ***They showed me dolls and books. I felt yucky and didn't want to look at the dolls. Then I started understanding what was going on.***
>
> Kathy, recalling her
> experience at age

As described earlier, for some children the experience is so unsettling that they close down and stop speaking or withdraw in fear afterwards. Julie's mother describes the police interviews as upsetting to her because of the questions asked, its length, and the number of people involved. A year and a half later, when she was interviewed, Julie no longer even remembers that these interviews occurred.

In addition to the difficulty that children experience with the personal nature of questions, and how hard it is for them to speak about their particular experiences with the visibility of some investigations raise their concerns about intrusiveness into children's normal life. Julie's mother felt that children should not be interviewed at school by police officers who arrive in uniform in a police cruiser. In another case, a social services investigation was conducted at school even though there were no protection issues. Most school counsellors felt that police and social services investigations carried out at their schools were handled with discretion and sensitivity. Occasionally, however, the worker's presence may be quite public and emotionally disruptive.

> ***A police officer arriving at school in uniform and waiting for the child at the classroom door in full view of other students and teachers.***
>
> ***Social Services have arrived and interviewed children without our knowledge of their arrival. They've got some students quite upset without telling us anything. On occasion, they've interviewed a child and left her hanging for some time before dealing with the family.***

Patricia's experience is a clear example of how an investigation can be in a child's life. She was interviewed by seven different police officers in two different jurisdictions over a nine month period as part of an investigation for court. She was repeatedly taken out of school for 2-3 hour interviews where she would ***"tell the same story every time"***. She even recalls being taken for an interview the afternoon of her prom, missing her hair appointment and having to rush home to see if the hairdresser could work her in just before closing to give her a ***"simple cut."***

3. Too many people, too many interviews, too many delays, too much time. Patricia's experience dramatically highlights some common concerns in the experiences

of children and families in our interview sample. In almost all cases in our sample, there were both police and social services investigations, (sometimes with more than one worker), and sometimes medical exams as well. Mothers voiced concerns about having to see ***"far too many people". "There needs to be only one person involved, and we have to relate to several personalities."***

This concern of course, is not specific to investigation. The interviewers observed that it was often very difficult for children to recall all of the different workers they encountered in investigation and to tell them apart. One suggested that perhaps workers from different agencies might wear different coloured shirts so that children (and researchers) could tell them apart more easily.

The number of people involved in intervention with sexual abuse requires a coordinated response if children and their families are not to experience it as intrusive (and chaotic). When such coordination is absent, the results are disturbing. Tara's mother recalls her daughter's experience.

> ***The police statements were inconsistent and different from what Tara had told them. There were three police officers. They were all terrific. No one seemed to know what the other was doing. There were some clashes between Social Services and Victim Services. All the agencies seemed to be stepping on each others' toes. We didn't know how things would proceed.***

Tara's mother understandably wished for one person who could have explained what would happen to them.

Number of interviews. Within our family sample, most children (64%) were interviewed only once by police ($\overline{X}$=1.76), but more extensively by Social Services ($\overline{X}$=2.60). Since some of these interviews are joint, it is not possible to determine the number of total interviews. Most (52%) children are interviewed three or more times by social services with 16% being interviewed five times or more. Workers are often placed in a real bind in relation to number of interviews. On the one hand, heavy caseloads can restrict the number of investigative interviews, a problem highlighted by our Advisory committee who noted that with young victims, repeated interviews and a slower process may be necessary. However, when they sometimes engage in that process, as they did with Anne and Karen at age 2 1/2 and 5 1/2, the long investigative process (more than 8 interviews) may be upsetting to the children and their families. Their mother stated that

> ***"Victims shouldn't have to be investigated.
It is revictimizing".***

Tara, described above, was also quite upset about an investigation with 5-7 social services interviews.

Delays, length of time. Children's sense of time is quite different from that of adults, and intervention is of course based on an adult timetable. In addition to raising issues of safety, delays in the process of investigation discussed earlier may also contribute to feelings of lack of control.

3. Support.

> ***The police were great. She talked comfortably to them. The social workers talked to her and made her feel good - they told her it wasn't her fault. Her social worker said that she could call her anytime. Things were good for Susan***
>
> The mother of Susan, age 6

> ***There was no help [for Patsy during the Social Services Investigation]. She didn't have anyone to talk to***
>
> The mother of Patsy, age 11

The time of investigation is one of great crisis for children and families. The lack of control and unpredictability over the events in their lives, and the extensive disruptiveness to their "normal security" mark this period as one of considerable stress. And like other stressors, their effects can hopefully be mediated by the presence of meaningful social support. Maternal support is one of the key variables that has been related to the child's adaptation, and the data presented in the previous section suggest that maternal supportiveness during the time of disclosure and investigation is fairly high, except when denial of the abuse is an issue. Social workers rated 71% of mothers as supportive of their children for current cases, and 76% of fathers were also seen as supportive. Our major focus here will be on the supportiveness of workers and other sources of possible help to the child.

Sometimes, the very mandates of the investigation can interfere with providing emotional support to children. One social worker reported feeling restrained in comforting distressed children during an interview because of the need to obtain "good evidence" for the legal process. Bob was one of a group of boys victimized by the same abuser. His mother reported that

> ***The social workers tried to make Bob feel supported. [But] because of the group dynamic, police wanted the social workers to stay out of it for a while.***

Jane, age 15 comments;

> ***I guess the social workers and the police believed me but they weren't very comforting.***

The mother of Mary, age 7, might have been perceiving of the dilemma of the social worker's mandate when she noted that she felt that the workers could have given a stronger message to her daughters that

> ***This is not acceptable and we're going to do everything we can to help you. They needed to hear in a strong way that this is not OK.***

As their mandate is presently constituted, social services workers are in a difficult position for providing maximum support to children during investigations. But from the perspective of a number of children and families, they do seem to be negotiating this delicate territory quite well. Almost all (84.6%) of the interviewed children felt "helped" by the social work investigators when asked about their overall perspectives on intervention. A number of parents (23.3%) identified the social workers as their major source of support during the disclosure and investigation period. Overall, compared to the children's view, parents rate social services investigators as not quite as supportive. In 36% of the cases they were rated as "somewhat" and "extremely helpful" and were more commonly seen as "neither helpful or hindering" (40%) to the victim during this time. The mean rating was only slightly above the "neutral point" ($\bar{X}$=3.33). Police were rated as slightly more helpful on the average ($\bar{X}$=3.60), and were perceived as helpful in 52% of the cases. Relatives were rated as slightly more helpful than workers ($\bar{X}$ = 3.70), and friends were seen as quite helpful to the children ($\bar{X}$=4.39).

Seventy percent of the children also felt "helped" by the police during the course of intervention, and a number of children and parents note supportive and sensitive responses during investigation and in the time period awaiting court.

As we have seen previously, the response to families where some ambivalence or denial is perceived is experienced as less than supportive:

> ***Janet's mother reported her upset at the police investigation. "Janet was upset by their negative attitude toward her parents. The police told Janet her father was no good. They tried to make her hate him. They were negative about me too. They thought this was supportive." She also reported that "the social workers broke confidentiality, they lied to her. They used her interview against her and her father."***

Mothers experience the impact of this reaction at investigation far more than the children do. A number of them seem to feel quite unsupported at investigation.

The most supportive responses workers make to children at this time appear to be ones that are at a "child's level." Bob remembers the pin the RCMP officer gave him several years later. Jason's mother recalls how the RCMP gave her son a chocolate bar and a ride on the elevator, and the mother of 4 year old Christie was pleased by how the worker got her daughter to draw and *" make it into a game."*

> ***I was kind of scared the first time because I didn't know her very much. She was always trying to help me and give me things to do while I was talking.***
>
> Julie, age 7.

Jane's mother offers a clear expression of what the core of a supportive response would be for children from workers during the investigation.

> ***[They need] a recognition by workers, affirming how difficult it to go through the process of investigation in plain simple words. 'This is hard.' 'You are brave.'***

Throughout the interviews with children and families, there are two particular suggestions for sources of support for children during investigation that emerge repeatedly.

First is the suggestion that they need someone to go through the investigative process with them, usually their mother, but sometimes, just a special supportive person. The level of distress of many children in the interview sample supports the merit of such a suggestion. Christie's mother was allowed to be present at the interview, and Katie's mother feels that her four year old ***"would have felt safe if she could have sat on my lap"*** (and perhaps not have hid in a corner for two hours afterwards). Tara's mother felt her daughter was upset because ***"she had to do the interview alone. She wanted her mother to be there."*** She suggests that

> ***They need to set up a support person who is not associated with Social Services who can help the victim through it. Someone who is like a Big Sister, who can support them but doesn't have any authority over them.***

The second repeated theme suggests the need for female police officers to investigate sexual abuse complaints. Comments about discomfort with male investigators or preference for female ones are made by a substantial portion of the interview sample

(23.3%). This preference is usually not a reflection of an insensitive response by a male officer. In fact, there are several male officers who are mentioned repeatedly in interviews with therapists and workers as responding to children in an extremely sensitive fashion. As the mother of 7 year old Carol suggests,

> ***The police officer was very good. [But] it bothered her that he was a man in authority.***

And as Jane, age 15, so pointedly puts it,

> ***I didn't want a man there.***

After the nature of their abuse experience, and considering the great potential that the investigative interview has for touching feelings of lack of control and safety, it would seem very helpful to victims to meet this need to increase their sense of support. Presently, on Prince Edward Island, this is very difficult to do, since there are very few female officers on any of the police forces.

IV.13 SUGGESTIONS FOR CHANGE:. When children, their families and adult survivors are asked how the process of investigation could be made better for other children, or more helpful for the victim, their ideas offer useful suggestions of how some of their needs for safety, control and support could be better met. The children identify three principle needs:

(a) **More of a child-centred process**, where children would have more control, be in more comfortable settings and proceed more at their own pace;

> ***Social workers and police coming to a kid's home.***
>
> ***It helps to let the kid know that if they feel very uncomfortable answering questions or aren't ready yet, they don't have to answer.***

Children's suggestions for more control over investigative interviews is supported by the research of Gilgun, (1984, cited in Wolfe and Gentile, in press) who found that children tend to give more information in interviews when given more choice, and suggests that a child's right to self determination in the interview should be placed at equal value to obtaining complete and accurate information. Adult survivors also reiterate the need for children to "talk when they are ready".

(b) **More sensitive, and supportive interviewers**;

> ***Help to say the exact words when you don't want to say them exactly.***

> ***Someone that really knows what they are doing should do the investigation. Someone who will the child deal with their feelings and who will help them not be afraid to tell.***

Children are aware of the special skill that is required to help them in this vulnerable time, and see the need for well trained and very sensitive interviewers.

(c) **More female officers.**

Among the mothers and adult survivors, the needs for supports to the child, and to the mother to support the child are emphasized. In addition to being present for children in interviews, both groups suggest the idea of ***"a person to go through it all"*** with children, someone to provide information, help them know what will happen, explain things to them, and assist them through the process. Some respondents refer to such a person as an "advocate". The need for less traumatic, more streamlined, and well organized investigative procedures is also highlighted, with an emphasis upon trying to remove the child from the actual investigation as much as possible, minimizing the number of times the child must repeat her story, and shortening the process.

Many of the problematics of investigation stem from the mandates and structures of different agencies, as well as from the attitudes, training and sensitivity of particular workers. To make investigation less revictimizing for children, problems at all of these levels must be addressed.

Perhaps, as Susan says, ***"It will always be difficult"***, but there are a number of ways in which investigation can be made far more sensitive to and centred around the needs of children.

IV.14 INTERVENTION - THE EXPERIENCE OF CHILDREN:

After the investigation, all children will experience some continued intervention into their lives by one of the several service systems if a case is validated.
Some will continue to be involved with social services who may make decisions about what needs to happen in the family, arrange placements, provide specific services, or continue to be involved with the child and the family for more generally supportive purposes. Some children will be involved in the legal process when criminal charges are brought against the offender. This could involve further investigation by officers, preparation for court by a variety of potential people (e.g. principally victim services and the crown attorney, but also possibly social workers and therapists), possible court appearances and testimony, and of course, considerable waiting. Many children will also be involved in counselling, usually at a community mental health clinic, but sometimes through a private agency. At times, of course, all of these systems and their workers may be involved in the life of an individual child at the same time. And this of course, is what results in the need for more coordination, so consistently mentioned as a central priority in a new system of intervention by many different kinds of workers in our formal and informal contacts with them.

Table 3.1 presents the frequency of the different types of interventions in child sexual abuse cases drawn from an analysis of past case records. A more detailed discussion of these patterns of intervention will be presented elsewhere. The focus of the present discussion is on the victims' experiences of these interventions.

Even though there is some overlap in the involvement of different workers with different aspects of the intervention process, particularly around the court process, discussion of the child's experience in intervention will be organized around the three major systems - social services, therapy and court.

IV.15 SOCIAL SERVICES INTERVENTION:THE EXPERIENCE OF CHILDREN:

In the time immediately following the investigation, social services' involvement centers around its protection mandate in relationship to the child, and investigative workers frequently maintain their involvement with the child and family. Initial intervention decisions are concerned with assuring the immediate safety of the child. Case records indicate that this is as likely done by a child's leaving home as it is accomplished through the removal of the perpetrator. In 29.5% of past cases, offenders were removed while victims had to leave their homes in 29.1% of the cases. Where children are removed from home, they are most commonly removed alone (73.8%), usually to a foster home or group home. This data seems to support concerns raised in our advisory committee about "revictimizing the child by removing them from their families."

Kelly's experience illustrates the level of stress and upset that may come from such family separation. Her mother had sought shelter at Anderson House when she learned of her daughters' abuse, and then had moved to a trailer away from the stepfather. When Social Services felt it was necessary to apprehend the children,

> ***They had to practically drag us away from Mom to take us to the foster home. I hated them [the social workers] with a passion. I think I bit him and kicked him. I hated the foster home and was really angry at everyone except Jackie [her sister].***

She was also bitter and angry about the consequences of her disclosure as stated earlier; ***"I lost my home friends, and school because he wouldn't leave."***

Other children may react more positively to this separation as Cindy did. When her mother refused to believe that her daughter had been abused by her stepfather, Cindy went to live with the family of the close friend to whom she disclosed and they became her guardians.

> ***My parents signed a form and I just stayed with my best friends' parents. I felt safe, and went there to have another home. My guardians were really good, friendly and understanding.***

Cindy's positive reaction to her "placement" seems to be related to having some control over what happened to her; to some extent, she had the opportunity to choose her own 'new family'. At one point, social workers' ***"decisions were laid on me"*** and they wanted to move her to a foster home in another community, but Cindy did not want to leave her school and her friends, and was able to influence that decision. She feels that the ***"social workers should ask for your opinion more"***, and now feels " ***informed, supported and understood***" in her relationship with her long term worker.

Sometimes, as with Cindy, children feel that workers are not aware of the importance of the existing supports in their lives. Kelly eventually did develop a good relationship with her foster father but

> ***Just as I was getting close to him, Jackie ran away and the next day they told me to pack my bags and took me to a group home.***

Both of these cases illustrate the importance of the sense of control and predictability that children require in their lives during this time.

It is likely that the earlier periods of intervention represent the most difficult time for balancing the child's needs for safety with their needs for some personal control. In trying to find the right balance in this dilemma, the messages that workers give concerning safety are sometimes confusing, especially to mothers. In her effort to be supportive, one worker suggested that her mother put her son, abused by someone outside of the home, into foster care. The mother was exasperated and surprised ***"How could that possibly help?"*** Karen's mother felt she did all she could to prevent visitation by Karen's abusive father, but the worker supported her daughter's request to see her father as her right and told the mother that it was her responsibility to see that her daughter was safe.

Mothers often appear to feel themselves to be in the background in the decision making process that goes on in intervention; more saw the victim as being involved in decision making by social services (57.1%) than did mothers as being involved (35.7%). They did, however, feel that they were similarly informed about decisions that were made compared with their children (57.1% for mothers, 64.3% for children). One therapist suggested that families may feel vulnerable when Social Services is involved because of fear of their authority. She recounted how intruded upon one mother felt coming home to find a homemaker looking at her bulletin board and going through her bills.

Among the small sample (N=7) of children who answered questions about involvement and information in intervention, all felt either "somewhat" or "very" informed in intervention decisions that were made. They were however, most often, "a little" or "somewhat" confused by intervention decisions and found them unpredictable.

In P.E.I., cases are generally assigned different long term case workers after the initial crisis of the first month or two is past. In addition to carrying out case plans and monitoring interventions, these workers may also be involved in an ongoing relationship over a long period to help meet the support needs of victims and families. On occasion, both the change and number of workers can feel disruptive or intrusive to children and families, as in Jane's case where she had five different social workers. One counsellor told of a family that got two new case workers a week before court who came to interview the child: ***"She was fed up; she felt like an autopsy"***. Another therapist expressed concerns about cases where ***"an intense relationship with an intake worker will be severed, often at a critical time."***

Children in the interview sample react quite positively to their long term workers. They feel that they have"good" relationships with their social workers and they rate them highly in friendliness ($\bar{X}$=4.44 out of a possible 5), understanding ($\bar{X}$=4.56), trust ($\bar{X}$=4.44) and supportiveness ($\bar{X}$=4.56). The adjectives endorsed by children about their feelings with their workers are almost exclusively positive and confirm this finding. But children still raise their concerns about intrusiveness and control.

> ***According to Cindy , her worker is "nice, she likes to help. But I don't like social services because they try to pump people for information."***
>
> ***I feel you have to be careful what you tell social workers. They can take it and use it against someone else or me.***
>
> Jane, age 15

Mothers' perceptions of worker's relationships with their children were favourable, but not quite as positive as the interviewed children. Workers were seen as friendly ($\bar{X}$=3.73), and their ratings on honesty ($\bar{X}$ = 3.33) and experience ($\bar{X}$ = 3.45) were slightly closer to the "medium" point. Once again, the difference in perception may be reflective of the position of conflict and nonsupport that mothers sometimes feel with social services. Lisa's mother felt that the workers could have been more straightforward with them:

> ***It would have helped Lisa if the social workers hadn't made so many promises and had been more realistic. They should have told her the truth about the system and the court so there would have been less disappointment.***

Lisa felt unprepared for (and upset by) the fact that one of her abusers was never prosecuted while the other received no term in jail.

Therapists are generally very favourable in their assessment of Child and Family Services workers. They also raise concerns about the level of knowledge and sensitivity of some workers in relation to sexual abuse. Part of the problem seems to lie in the amount of rotation of workers. One counsellor felt that it was difficult to make any generalizations about Social Services responses to cases because ***"it all depends"*** upon individual workers and supervisors and outcomes were therefore, quite unpredictable.

Some of the issues raised by therapists about social services intervention are quite "interorganizational" and will be discussed more in the section on service agencies (e.g. coordination and communication). But other aspects of their perceptions most relevant to the nature and quality of treatment and other services is germane here. An analysis of case records indicates that about 61% of cases have been referred to public and private agencies for therapy. A number of therapists, however, seem confused about both the basis and timing of referrals. one case is referred and another is not, and one counsellor suggested that services offered to victims and families seemed to be either *"feast or famine,"* sometimes with a great deal of early involvement with very little follow-up. Several therapists commented on how a Social Services worker would sometimes not follow up a case once a referral had been made, when a more collaborative relationship might have been very helpful. Another reported how pleasantly surprised she was when a worker called to ask how a child was doing in therapy. *"That was very rare."*

In addition to providing the referrals for therapy, Social Services intervention may involve temporary cr long term placement in a foster or group home. One therapist was concerned that there was *"not enough emphasis on working with family ties to strengthen and support the child. There's too much reliance on outside placement."* Within our interview sample, however, the use of such placements appears to be quite careful and judicious, and frequently, quite helpful to the child

> *Kathy went to a foster home when she was 11 after the abuse was disclosed. "My foster parents are caring. They were supportive. I went back home, and then back to the foster home. I'm still there. My foster parents were there when I needed them."*

For some children, the experience of the group home has been most positive in helping them not only to experience some support, but to help them deal with the isolation of their abuse. Jane recalls that

> *When I went to the group home, I started going to school steadily. I made friends easily there - I felt connected. I could talk to a lot of the kids. Almost all of them have been sexually abused.*

Jane identifies her group home worker as extremely supportive to her. Kelly had a comparable experience after a distressing foster home placement. Susan, like Jane, was given some choice in her group home placement, and feels that the setting is giving her *"time for myself to stop getting into trouble. Rules give me some control of my life."*

IV.16 SUGGESTIONS FOR CHANGE:. Once again, the children's suggestions about what is needed at this time reflect and support what is evident from other sources of inquiry. For them, intervention would be better for children if they had (1) **more control**; (2) **more helpful, sensitive and informed workers**; and (3) **more personally suitable placements.** Susan suggests that

> ***You should make more decisions for yourself. [they should] stop telling you what to do all the time. Give a little more space and not try so hard to get information***
>
> ***Jane suggests that "In group homes, kids should be more involved in the running of the house. Kids should be able to read the notes that workers put in their file.***

Children are also concerned that workers have a better knowledge base (e.g about child sexual abuse, drugs), and Jane reiterates a theme about sensitivity to gender of workers introduced earlier.

> ***In group homes, male workers that give us the creeps shouldn't work there.***

IV.17 THERAPY: THE EXPERIENCE OF CHILDREN:

> ***We talked about the abuse and all that was going on in my life. She explained everything until I understood and she could tell if I didn't understand. She always makes me feel better. I could tell or ask her anything.***
>
> Susan, age 15

Many people "touch" the victim during her intervention journey, and the hope is that such encounters are helpful and supportive, communicating to her feelings of acceptance and belief that can help to provide the sense of safety and security she requires in her effort to recover from the effects of the abuse. The major work to bring about this recovery is usually identified with the therapy process. It falls to counsellors to help the child cope with and work through the abusive experience and to help her move in more positive developmental directions.

Therapists we interviewed tend to "moderately agree" that most victims need some professional treatment in order to recover from sexual abuse. Therapists and adult survivors also strongly suggest that the process of recovery is certainly not confined to therapy, that it is a very personal process that takes considerable time and that the survivor must direct this process on her own in some way. The role that therapy plays in this recovery process is far from clear. As organizations, "mental health" clinics have their roots in models of "treating pathology", and as such, may be unaccustomed to locating the sources of recovery within clients themselves. But therapists and survivors, and theorist/practitioners like Sandra Butler (1989) all suggest that clients know how their own healing process should proceed.

For the most part therapists regard work with sexual abuse as being fairly specialized. While they emphasize the importance of more "generic" therapy skills pertaining to the relationship, they believe that therapists required a particular knowledge base that should be regularly updated to work effectively with sexual abuse victims, especially since "the field is still fairly primitive in theory and research." At least several therapists expressed the opinion that there are no experts (or very few and especially not on PEI) in the field because of this. There are, however, therapists who do present themselves as experts, and this has engendered some conflict within the therapeutic community. For this, and several other reasons, there are barriers in referral and communication that contribute to an under utilization of some therapy resources. This is a major problem in a rural area where resources are scarce.

Referrals. The main source of victim referrals to therapists appears to be Social Services. Most therapists identify this department as their major source, and the information collected on children in therapy identified 43% of the referrals as coming from Social Services. This, however, could be somewhat underestimated since several therapists with significant caseloads did not complete these forms. Interestingly, mothers were a very common referral source in this sample (40.5%).

The analysis of case records indicated that Social Services referred a substantial percentage (61.5%) of the children whose cases they validated for therapy, as well as 50% of their families. And while a number of our respondents in the study have emphasized the importance of therapy starting as soon after disclosure as possible, families report that the speed of referral is highly variable. While 31.6% of them were referred for counselling within a week, and 42.1% within a month, 42.1% were not referred for three months or more. Counsellors were as puzzled by the slowness of some Social Services' referrals as they were by their patterns of referral discussed earlier and didn't understand why referrals could take up to 8 months to be made. One counsellor who had previously had a child sexual abuse caseload had received very few referrals in the last year. (*"I'm not sure where they're going*"). During one part of the study period, there were few active therapy cases but a considerable Social Services caseload of sexually abused children.

In a number of cases in our interview sample, the delays in referral are lengthy and it is difficult to understand why.

> *Twelve year old Judy has had quite a positive counselling experience, but she describes the one year delay as "too late," and wishes she wouldn't have had to wait for so long*
>
> *Katie was assessed in another province when she was five, and "they said she didn't need counselling. Her mother indicates, "she was showing all kinds of problems – tried to stab herself with scissors."*
>
> *Kathy did not start therapy until seven years after the investigation, even though she has had considerable intervention in her life. She is now 14. "I like going for counselling. I wish it had started sooner."*

It was seven months after disclosure until Anne and Karen, ages 2 1/2 and 5 1/2 were seen in therapy.

It's not clear in most of these cases what assessment, if any, was done that contributed to decisions to not refer these children sooner. Workers have reported a concern about their ability to assess immediate psychological risk and perhaps these slow referrals reflect their difficulty with this process. These cases suggest the need for a more consistent approach to therapy referrals to assure that an immediate therapeutic response is available when needed and the value of making a more formalized, extensive and collaborative model of assessment available in all cases.

Therapy characteristics. (a) Modality. Interviews with therapists indicate that most work is individual in nature, with considerable use of family involvement. Most of the time, therapists will work with parents, (almost exclusively mothers), to given them information to help them understand their child's reactions, provide ideas about how to talk with their child about sexual abuse, and to increase their supportive involvement with the victim.

Work with parents is often age-dependent; with younger children, parents may be taking on considerably more therapeutic responsibility. Parental involvement is seen as an essential aspect of therapy by a number of counsellors. As one therapist put it ; ***"Mobilize the support of the parents and you've got 3/4 of your work done."*** In most cases, therapists are attempting to develop such parental support; 81% of the interviewed parents were involved in their children's therapy. Therapists also feel, however, that lack of attention to the therapeutic needs of nonoffending parents and families is one of the most glaring areas of unmet need.

At the present time, there are two groups for girls run in the province, and therapists will sometimes use some individual work to get children ready for the group experience, and meet individually on occasion with group members.

(b) Number of sessions - In our sample of families, children attended an average of approximately 11 sessions, with 36% having more than 12 sessions, and 18% having fewer than eight. This average is consistent with the data gathered from information on children in therapy ($\overline{X} = 11.4$). There appears to be more variability in this later sample, with more children receiving fewer sessions; 44.2% are seen five times or less.

Sessions are typically an hour long, and held each week or second week. Groups appear to run 12-14 sessions; one focuses on stress for children, and includes sexual abuse as an issue, while the other is directed toward sexually abused girls. No groups have been run for male children in the province.

IV.18 THE THERAPY EXPERIENCE:

> ***I see her a lot. Twice a week on Tuesday and Friday. I don't want to go because it's sad. We talk about things in my life, like Mom and Dad. And that makes me feel bad. We talk about my uncle [the offender] and I'd rather not talk about that. We get along good.***
>
> Jennifer, age 9

Therapy is difficult for children, particularly dealing directly with their sexual abuse. While there are some, like Mary, age 7, who says ***"I like to talk about it because it gets my feelings out,"*** children most commonly report considerable discomfort with these discussions. They often refer to them as "too personal", but like Jim, they may conclude that ***"talking about the details is hard, but it helped me feel better."*** Therapists perceptions of children's feelings in therapy offers a striking confirmation of the difficulty they experience. While children do appear to be quite comfortable in the therapy relationship, therapists perceive them to struggle with many negative feelings in therapy: only 13.8% of the adjectives endorsed were positive, supportive ones. Most commonly therapists perceived children as feeling angry, confused, scared, mistrustful and isolated.

From the perspective of the child, it is not difficult to see therapy as another extension of the powerful adult world that holds out expectations for them to meet. While there had been such "performance expectations" in investigation, and of course, in the abuse itself, therapy presents children with something of the same dilemma. All our therapists regarded direct work on the abusive experiences as important, although there was considerable variability in the degree of attention and the nature of the approach. Karen, age 13, captures the flavour of the experience of such an expectation.

> ***I find it hard to talk on cue, but I'm***
> ***getting used to the idea.***

Therapists seem very sensitive to this dilemma, and all have developed their own means of negotiating how the abuse is going to be discussed with the children. Most commonly, they will review reasons for referral with them, and try to present them with a variety of opportunities for discussion of the abuse as the therapy develops. Most will try to ***"find a balance between the everyday stuff and the sexual abuse,"*** which the children tend to appreciate; ***"We talk about everyday problems - those are most important"*** (Kathy, age 14). The way that therapists handle the discussion of the abuse experiences is central to the issue of children's experience of control.

IV.19 GENERAL PERCEPTIONS AND EVALUATIONS OF THERAPY: Table 4.1 presents data on several measures concerning perceptions of the therapy relationship and the effect of therapy on children from several different perspective. Although these are drawn from several different samples (children, families, therapists) with sometimes slightly different measures and only some overlap in the cases, there are marked similarities in the findings across samples[**]. All groups are favourable in their general evaluation of the relationship, and its more specific aspects, with most ratings appearing in the good to very good range. This finding is also consistent with the adjectives children use to describe their feelings with their therapists: 78% of the descriptors chosen were positive and supportive ones (most commonly liked, cared for and understood). Of the relationship variables, children and therapists seem to differ most in their perceptions of trust with therapists seeing children as somewhat less trusting than the children themselves do. These are, of course, highly selective and different samples, since therapists were major referral sources, but the similarities do suggest reasonably accurate therapist perceptions. And while most of the relationship ratings are very positive, it is important to note that a substantial proportion of parents (18.2%) felt that their children did not have confidence in the therapists ability and experience. Two of our 12 child respondents (16.7%) also felt that their therapists were "not at all" on their sides. Therapists also perceived their relationships and levels of trust with mothers to be reasonably good, and only slightly below their ratings with the children themselves.

[**] All continuous rating scales have been converted to a six point format for purposes of comparison.

The three samples also have strikingly similar perceptions about therapy effects, with only small differences between the number of children (75%) and parents (65%) who regard therapy as helpful Therapists endorse the criterion of "some progress" in a higher percentage of cases (83.7%), and see "considerable progress" with substantially less frequency (48.9%). Therapists also felt that their major therapeutic goals with clients were met at least "moderately well" 76.7% of the time.

When the children's experiences in therapy drawn from the interviews are examined to identify some of the sources of their positive and negative evaluations, the themes related to victimization again come into focus.

TABLE 4.1

CHILDREN'S, PARENTS' AND THERAPISTS' PERCEPTIONS OF VARIABLES RELATING TO CHILDREN'S THERAPY

	Respondent +			
			Therapists (N=43)	
	Children (N=12)	Parents (N=26)	with children	with parents
Relationship with therapist				
Overall relationship *	4.70	NR	4.58	4.31
Friendliness	5.28	"positive attitude" 86.4% "yes"		
Trust	5.00	72.7% "yes"	4.51	4.36
"On your side"	4.99	NR	NR	
Confidence	NR	54.5% "yes" 18.2% "no"	NR	
% understanding	NR	NR	4.51	
Effects:				
% "helped"	75%	65%	83.7% "some progress" 48.9% "considerable progress" or more	

+ Children and parents' ratings are drawn from interviews. Therapists' ratings are based on "Information on Children in Therapy".

NR no comparable rating was obtained within this sample.

* All ratings have been converted to a 6-point scale with higher numbers reflecting more positive ratings.

Control Issues: The experience of control appears to be particularly important to children's therapy experiences. Carol's mother describes her 7 year old daughter's first encounter with a counsellor.

> ***She was taken to see [the therapist] and told words she didn't understand. She needed someone to be on her level. She didn't feel comfortable with the therapist. She asked [Carol] if there was intercourse and Carol didn't know what it meant - she cried. She seemed to be pushing our daughter to take the case to court and we didn't want to. She wanted to put our daughter in a group. She didn't want to be with others who had worse things happen to them.***

Understandably, Carol never returned to therapy or sought another therapist. Fortunately, she had strong family support, the offender was outside her immediate family, and the court process was nontraumatic. A year later, her mother reports her as doing well. But her experience reflects many of the key themes concerning loss of control and its relation to revictimization. She felt pressure and intrusiveness from a therapist who was unable to relate to her on her own level or at her own pace. Carol also appears to have perceived herself as having little choice about the form of help being offered which she did not want. Many of the adult agendas are very evident in the response to this child. Like her precocious sexual experience, she was presented with much more than she was ready for.

Sometimes, what children are not ready for is the therapy experience itself. This creates some very significant dilemmas for families and helpers, who may see considerable distress in the child, or behaviour problems that appear related to the abuse. But when children feel pressured to go to therapy, the results seem to almost always be negative. Bob has seen three therapists on the Island:

> ***I was seeing a counsellor before the police investigation. I didn't really want to go but my mother wanted me to. We talk about the abuse, how I'm getting along. I didn't like any of them. I don't get any choices. [It has] made no difference.***

Bob endorsed the words "angry, blamed and mistrustful" to describe his feelings with his therapist. Bob does have some significant behaviour problems, and is currently in a group home. While he may be easily evaluated as needing therapy, he clearly doesn't want it.

Cindy's experience is quite similar. There was a quick referral and therapy began shortly after disclosure.

> ***I went right after disclosure, once a week for three months. [There was] individual work and then group work. I didn't want to go. I disliked it. Talked about feelings and everything, [I] just didn't like it. There were some things I just didn't want to talk about. [I] didn't like the group. [I] didn't like telling other kids my problems. There was nothing they could do for me. [The counsellor] was nice enough. I just didn't like counselling. My step-father should have gone.***

All the ingredients for a positive therapeutic experience are here - except the client. This theme emerges repeatedly because it has happened with a substantial number of children. Lisa had a poor experience with her first counsellor. Her mother suggests that ***"the first time, the timing was wrong. It wasn't the counsellor, Lisa was just too mixed up."*** Cheryl's mother thought her daughter's counsellor was ***"a good therapist, but she wasn't ready."*** Patsy went to therapy after a guidance counsellor referred her, and her mother suggests that ***"she just went because she had to - she didn't really want to go."*** One therapist recalled a case where foster parents insisted that a child not miss any therapy sessions even though the therapist herself had given the child permission to do so.

These examples stand in clear contrast to the experience of Julie, age 7, who was initially quite shy with a group and whose ***"parents wanted me to go, but if I didn't want to, it was fine with them"***. In time, she found the group quite helpful.

Therapists place a great deal of emphasis on client control when they describe the major features of their work.

> ***From the time I start, I believe that the person should have as much control as possible over the content of the discussion. I don't believe at all in structuring when certain talk should occur. It's abusive if I force such topics.***

> ***I'm very client centered with them. I go where they want to go.***

> ***I tend to let those clients take more control over how therapy goes. They need to reestablish control over their lives. I tend to collaborate to a large extent. I'm directive in a more gentle way, being very careful not to revictimize.***

The control theme appears repeatedly in the stories of recovery that adult survivors tell with their encounters with a variety of counsellors. Experiencing a sense of freedom, self direction and control of the pace of therapy appears to be a key ingredient in their therapy process.

> ***I set the pace in therapy, but she always went back to things I skipped over or didn't want to talk about.***
>
> Laura, age 32
>
> ***Both the therapist and myself lead therapy.***
>
> Martha, age 25
>
> ***I have freedom but she directs it.***
>
> Barbara, age 39
>
> ***She allows me to run the sessions.***
> Sandra, age 28

Clients will experience their sense of control in a variety of different ways within the context of therapeutic relationships that appear to be highly collaborative. And while therapists might have expert knowledge, it appears very important that clients need to be at the center of the process that determines when and how that knowledge is used. Many survivors refer to the use of reading and self help materials used in therapy, such as The Courage to Heal, and one survivor was quite upset that a previous therapist had this resource and had not worked from it with her. It appears that therapy must be useful to the survivor on her own terms, or it will not be useful at all.

For children, the means of experiencing control in therapy may be quite similar to that of adult survivors. Control means being able to influence the content of discussion, and as therapists suggest, moving at one's own pace, and at one's own level. A number of parents identify the helpful aspect of their child's therapy with the counsellor's ability to work at their child's level because she ***"gave the boys the opportunity to be children"*** or ***"goes at Katie's pace"*** or has ***"good communication, at Donna's level."*** One mother, sensing this need, wished that children had more activities in therapy. For Kelly, it was helpful when her therapist

> ***came to my level and talked to me as a kid would to a kid.***

This need to connect with children on their own level, and to engage in age appropriate activity is important for therapists to acknowledge, but is sometimes difficult to meet very well because currently there is no well developed setting for play therapy in any of the clinics on the Island. This is an important need to address especially for the treatment of younger children.

Another aspect of the therapy process related to the theme of control that emerged from the adult survivor interviews concerns their search to connect with a counsellor who can help them with their recovery. Within, our sample it was quite common for survivors to have seen a number of therapists before finding someone who was particularly helpful to them. Sometimes, this occurred because therapists did not inquire into the sexual abuse, ignored it, minimized it, or lacked any real experience and knowledge about it. Given the broad age range of our survivor sample, many of their therapy experiences occurred in a context of considerably less awareness and greater denial than the present. In other cases, survivors seem to be searching for someone with a deeper knowledge and understanding, and who helps to create an atmosphere in which they can effectively work. But making such a useful therapeutic connection is not entirely a function of expertise and experience. Within our samples of survivors, children and parents, there were some markedly different client reactions (and perceived therapy results) with a number of counsellors with good background in sexual abuse work. These reflections suggest the need to broaden the options and opportunities available for treatment. All clients will not be ready for therapy at the same time with the same people.

The narratives of the adult survivors certainly suggest that recovery is a process that takes some time, and that therapy may be useful at different stages in this process. One survivor consults therapist periodically for several sessions when she *"gets stuck"* so that she can continue with her own work with herself. The view that recovery may take place in "stages" and the need to make therapeutic opportunities available in this manner may be especially relevant for particular groups of children. Therapists generally see the motivation for therapy of some children as rather tenuous and fleeting. For example, teenagers *"have a low tolerance for therapy. You must work hard with teenagers to keep them interested"*. Even when interested, therapists seemed to feel that children's attention span was reasonably short, and that they are anxious to finish with the sexual abuse and get back to living their lives. They identified 25% of the children they described in therapy as *"terminating prematurely"*. One therapist suggested that *"after 3 or 4 months, most teenagers have had enough, and then they close off. You can only do so much work at a particular time. You have to try to be sensitive to that."*

Safety issues. Children will need to feel a sense of safety and security in therapy if they are to explore and resolve the painful feelings associated with sexual abuse. To feel safe and protected, they need to perceive therapists as trustworthy and experienced.

The most profound betrayal of trust is obviously sexual revictimization itself, and two adult survivors reported such deeply disturbing experiences. Gail told of her abuse by her foster father which she reported to her social worker who didn't believe her. Laura, now 32, clearly describes her experiences with a counsellor with whom she was discussing her sexual abuse when she was 19:

> ***He told me to write my uncle's name on a two pieces of paper and rip them up. That was helpful for a moment. But then he sexually abused me . That was the single, most devastating experience in my life. I really trusted [him]. I really thought he was different than the other men in my life. After that , I thought there was no one I could trust ever again.***

Laura's experience clearly focuses our attention on how central the abuse of authority and trust are to the experience of victimization, and how exploitative of a child's vulnerability.

The experiences of other children and survivors in our sample, while not as profoundly destructive as Laura's experience, also reflect deep concerns about trust and safety. Jane's counsellor, described earlier, minimized the importance of her abuse by her father, and dismissed it as not particularly serious. In other cases, concerns are raised that therapists are not straightforward with clients.

> ***Janet's mother felt that "Janet didn't trust her therapist because she lied to her by saying that she had handled it well, and then saying she hadn't in the presentence report. She didn't have confidence in her because she gave her a snow job and [Janet] accepted it.***
>
> ***Allen,an adult survivor, saw one counsellor for three sessions before stopping. "She picked a devious manner of exposing information and broke confidentiality. She didn't understand the ethics involved. It was hard to trust especially after this experience."***

Experienced and knowledgeable therapists are also central to the client's experience of safety. Gail, age 26, felt that her therapy with a counsellor three years ago made things worse for her and expressed her frustration:

> ***I'm sick of therapists thinking that they know everything. We hardly focused on sexual abuse. She told me that she didn't know anything about sexual abuse - that I had to teach her about sexual abuse. What help is that?***

Generally, the children interviewed seem to perceive their counsellors as knowledgeable. They voice the importance of therapists being well informed about sexual abuse.

> ***[Should] have more counsellors available like mine. She seems to be very well educated in her field and knows a lot about sexual abuse. We need more counsellors with training in sexology. Kids that have been sexually abused shouldn't be sent to a counsellor who isn't educated.***
>
> Sue, age 18

Janet felt that we ***"need better counsellors that know about child sexual abuse, alcohol and drug use"*** and Mary, age 7, suggests that

> ***It would be nice to have a counsellor who was sexually abused when they were young so they absolutely knew how hard it is.***

Tara's mother reflects a similar concern about counsellors' understandings when she says that her daughter ***"didn't feel the therapist knew about sexual abuse on an emotional level because she had never experienced abuse herself."***

Occasionally, mothers in our sample raised concerns about the counsellor's level of experience with sexual abuse cases. According to Patsy's mother, her daughter ***"didn't feel the therapist had enough experience with kids"*** and Jane's mom would not refer another child to her daughter's therapist because she felt that she wasn't experienced. enough. Cheryl's mother felt her daughter's therapist was

> ***knowledgeable, but it came from books. There was too much intellect and not enough feeling.***

This mother seems to have a good sense of the developing nature of expertise in sexual abuse, which many therapists express themselves: ***"we're all just learning about this"***.

Support. As indicated in the relationship ratings, children, particularly those who are not pressured into therapy, generally feel quite supported and understood in their relationships with their therapists. The experiences of support seem to be a central therapeutic ingredient for these children. Many of their comments reiterate mothers' identification of help with difficult feelings, particularly anger and self-blame, as a major category of therapist helpfulness. Sue says she can ***"really vent my feelings"*** and for Kathy, ***"It has helped that I can get it out in the open with people who want to listen"***. Janet's mother felt that therapy ***"helped her [daughter] deal with anger"***. Considering how common therapists report the experience of anger to be in the children who are their clients, it appears to be a key issue to work with. Especially with young girls, who are more likely to be socialized to inhibit their expression of anger, such work may be a key aspect of preventing their revictimization.

Children and mothers also find therapists helpful in dealing with their feelings of guilt and self-blame.

> ***The best thing is finding out I didn't do anything wrong.***
>
> Katie, age 9

> ***[The therapist] took a lot of guilt away from my son about the abuse.***
>
> The mother of Bob, age 15

The narratives of the adult survivors offer clear illustrations of how important it is to address and resolve such feelings in childhood. Shame and guilt appear to be very difficult to eradicate, and survivors' advice to therapists and sexually abused children devotes considerable attention to blame themes. Sarah advises therapists to

> ***Make them understand that the shame is not theirs. It's not a sin that it felt OK to them...that's normal sexuality.***

For some children, the experience of being in a group has been very helpful in overcoming the isolation that they have felt stemming from their abuse.
Katie was eight when she entered her group:

> ***I felt happy because I had thought that I was the only one who had gotten abused.***

> ***Julie, age 7, has positive memories of her experience. "There were lots of kids in the group - 3 kids and one grown-up. It was nice because no one laughed at you if you said something."***

Others indicate a need for such a group experience. Jane, who observed that many of the children in her group home had been abused says

> ***I would like to pick a group of kids, a safe place and a trusted person to facilitate a group for us about sexual abuse and what it does to you.***

As indicated earlier in the discussion on control, children who do not wish to be in a group will generally react negatively to it. And those who are unmotivated for therapy are likely to be even more put off by a group than by individual counselling. A number of therapists expressed the need for more groups, and the personal desire to be involved with them, but found that time and organizational problems seemed to make them very difficult to arrange.

Families: further observations: As indicated earlier most therapists involve families in their therapeutic work with children. Family support is seen as a key element in children's recovery, and therapists may use mothers as primary therapeutic with younger children, or provide some information to parents of older children to help them evaluate signs of distress in the children. Some would like to use foster parents in such a way as well and saw them as an ***"untapped therapeutic resource."***

Therapists also expressed considerable interest in some "restorative" family work with relations between victims and nonoffending parents and siblings. It appears, however, that this rarely occurs very directly, which may be a function of both time constraints and expertise. Of the four primary client groups (children, moms/families, offenders, adult survivors) therapists evaluated, they felt that the therapy community had a relatively low level of expertise and resources for mothers and families. This was consistently highlighted as an area of great need, and very relevant for victims. Family work was seen as needed in extrafamilial cases as well.

However, therapists interest in family work generally does not extend to the goal of complete family reunification. On the average, they slightly disagreed with this as a goal in incest cases. While some thought that it was a worthwhile goal in theory, and another outlined some considerations for how it needed to be done, most therapists indicated that they had never seen a case where the family had been "successfully" reunified. One indicated strong reservations about whether children's safety from reabuse could be assured, and estimated that it could be in only about 2% of the cases. Patsy's mother expressed a similar concern:

> ***My father has been receiving treatment and no one in the family has been informed of his progress. I worry about my father when he's through with therapy. Can we trust our children with him?***

The lack of familiarity that most therapists of victims seem to have about local offender treatment programmes, as well as the considerable reservations they have about their general efficacy, contribute to the concerns voiced about children's safety. None of the families in our sample did "successfully reunify", although parents are currently living together in several incest cases, where the daughter is living out of the home.

In several cases, there was some therapy with these families, but without much effect. Jane felt that ***"It didn't make much difference"*** and Kelly said ***"It wasn't useful; we couldn't talk in front of him about the things that happened."***

Regardless of therapists' attitudes and experiences about maternal ambivalence, and family reunification, it appears that a number of the couples will reunite. Whether or not a truly safe context could ever be created for the child within such a family is open to debate. And perhaps, the existence of family treatment, like some views of offender programmes, might offer a false sense of security that could increase risk and pressure to children. But clearly, without any therapeutic resources for dealing with these families, a child's safe return to the family will be highly unlikely.

IV.20 THERAPY: A PERSPECTIVE

This study is not an evaluation of the effects of therapy and currently there is no systematic program of treatment for sexual abuse cases. But it is worthwhile to speculate on what therapy seems to be doing presently in order to better identify needs. Currently, a number of aspects of therapy appear to be working quite effectively. Children appear to have good access to therapy services and good working relationships between therapists and their referral sources (e.g. see guidance counsellors comments in the "Communities" section) allow for more immediate therapeutic response for children in crisis. Therapists seem to be providing safe and supportive interpersonal atmospheres for children in which they can express feelings, and feel believed, accepted and understood. Levels of trust between therapists and children are good, and contribute to thorough attention to some central therapeutic issues such as blame and responsibility. Generally, children, parents and therapists rate therapy as having a positive effect on children. It is not clear, however, how often therapists are able to help heal all the wounds that result from the sexual abuse and successfully address the more "long term" needs of these children relating to deeper problems with self-esteem and self concept.

Several cases seem to reflect such unresolved long term needs.

> ***Lori's mother states that "[The therapist] was helpful even if the therapy itself was not." She saw no changes, and felt that Lori needed more therapy that was ongoing. Two years later, she still has self destructive tendencies when she's upset.***
>
> ***Katie, age 9, sees her ongoing therapy experience very positively. But her mother recounts how "she gets angry and aggressive, is very fearful, is having trouble in school, and is self-destructive, almost suicidal"***

Kelly had a very positive reaction to her therapy at the time, and a good relationship with her therapist that she found very helpful. But several years later, she attempted suicide and was sexually revictimized.

Children often come to therapy deeply wounded by their sexual abuse. Therapists rated the impact of the abuse on their clients' lives as between moderately and extremely negative and assigned a comparable level of emotional upset to their experiences. And as the analysis of case records indicated earlier, it is not uncommon for these children to come from families where there are other problems. Given the nature of the needs to be addressed, the therapy resources available appear to be limited. From out (non-representative) data based upon clients largely referred by therapists, children have an average of about 11 therapy sessions and therapists note that they often do not have the time to the kind of work with families required to help create a more long term supportive environment for these children.

It is important to develop a perspective for viewing therapy as part of the process of recovery rather than as the only solution. It is also important to recognize how difficult therapy can be with these children and how hurt they are. Recovery from the trauma of sexual abuse appears to be a process rooted within the life of the victim that is very individual in nature. Often, but now always, resolution of this trauma can take a very long time. This trauma may be exacerbated and prolonged by other aspects of intervention, most notably court. It is imperative that a variety of option be available that children can utilize when they are ready and at their own pace that can help to provide them with the "tools" and resources to aid in their recovery. Therapy is an essential ingredient in this including the options for ongoing intensive individual and group work, and making this option available requires addressing issues of training and personnel. But the development of other sources of support in the child's life is of equal importance, both within the family and the community. The aim of this process should be not only to deal with and resolve the experience of victimization, but to empower the child toward self-development and self-determination.

IV.21 SUGGESTIONS FOR CHANGE: When children and adult survivors are asked what they would change to make therapy better and to facilitate recovery, their comments center around several themes.

(1) The need for more **counsellors who really know about sexual abuse**. Children felt that therapists ***"need to know how sexual abuse makes you feel"*** and ***"absolutely know how hard it is."*** One mother noted that children know when they don't have an experienced counsellor and that they feel ***"cheated"***. Several children commented on the fact that their counsellors were knowledgeable. All but three of the adult survivors mentioned some form of therapy or counselling as central to recovery.

(2)The need for therapy to be **more "child-centred"**. Children's need to have control over the healing process is also a focus of the adults survivors. The advice to therapists that follows provides more detailed suggestions about this theme.

(3) The need to talk with other children about it, e.g. in **groups**. Many adult survivors (60%) also specifically suggested the value of group work in recovery, to ***"decrease isolation"*** and ***"show they are not alone"***, and it was noted that groups might be more useful at particular ages.

Advice to helpers:

> ***Do not say, I know how you feel.***
>
> Alanna, an adult survivor

When children and survivors are asked to give advice to therapists and helpers about how to help sexually abused children, they offer some clear directions.

(1) **Give children control and trust their process**. Children clearly don't want pressure in the helping process. Jane tells helpers

> ***Don't push kids to talk. Let them go at their own pace. Remembering takes a long time.***

Cindy suggests that counsellors should

> ***"wait for kids to open up. Don't push them. Treat them as if they can trust you and let them talk when they want to."***

Obviously such a process requires considerable patience and time. Adult survivors advise therapists to ***"trust the client"*** and to ***"not be afraid of the child or their pain"***.

(2) Demonstrate **sensitivity to the child's experience**. Helpers need to first be attuned to the child's pain and vulnerability, to ***"know the depth of the hurt in the victim".***

> ***Be more sensitive to what kids are going through. Put yourself in the kid's shoes.***
>
> Pamela, age 15

Another aspect of such sensitivity involves the need to create a context that is more suited to the child's world: ***"slow down, talk to them at their level, ensure you understand, [and] make them feel comfortable"***.

(3) **Provide belief, safety and support**. Children need to know that ***"they're going to be safe and nothing is going to happen to them"***. Helpers need to ***"believe and make sure they [children] know you believe"*** and to ***"make sure that they make kids know they understand and that they will help."***

A central need for children's recovery is well put by Wendy, an adult survivor.

> ***Support them all the time.***

(4) **Assure children that they are not to blame.** Adult survivors emphasized the importance of this message to children, and the need to work on the guilt that they may feel about such concerns as their role in breaking up their families, their own sexual feelings during the abuse, or even their feelings during the process of intervention itself.

> ***The shame and guilt are often severe; because of investigation and court and therapy, the child is picked on and feels bad.***

(5) **Provide open discussion and information.** Children need an atmosphere of openness where they can discuss any issues and be well informed. Sometimes, they seem to sense a helper's reluctance or discomfort with sexuality and sexual abuse.

> ***She won't tell me stuff. I want her to tell me about sex and what it's about, because he did things to me a bunch of times.***
>
> Jennifer, age 9
>
> ***Be more open to talk about sexual abuse.***
>
> Katie, age 9

Therapists, like other workers, must strive to find a good balance between providing safety and providing control for their sexually abused clients. Being well informed is a central aspect of feeling such a sense of control.

IV.22 A PERSPECTIVE ON THE THERAPEUTIC NEED OF ADULT SURVIVORS:

The principal aim of this study is to identify the needs of children who are the victims of sexual abuse in order to develop a model to effectively meet those needs. Untreated children grow into adult survivors of sexual abuse, and the profound impact of abuse on their lives has been described earlier. Currently, adult survivors make up a considerable proportion of therapists' caseloads. The following discussion will describe what we have learned about the therapeutic needs of adult survivors from interviews with them and with therapists. While a model of services for this group of victims is not part of this proposal, such information should be useful to those who provide and plan for the development of services for these clients.

Time and expression. The narratives of adult survivors suggest the need for time for the process of healing to take place. They need time to ***"talk it all out"*** and to ***"tell their story over a lengthy period of time,"*** even to express things that may seem ***"trivial"*** to others, as long as they can ***"say what they wish"***. In particular, they need to feel and express their pain and their anger, to ***"come into contact with the unpleasantness of their childhood"***. But it is important for adult survivors to ***"do more than talk about it"*** and therapists make references to finding ways helping clients to ***"externalize"*** their feelings to ***"get it outside your body."*** (e.g. through art work, collages, exercises). Survivors mention letter writing, role playing and keeping journals as helpful in this process and a number make reference to the Courage to Heal as a resource. Such an approach also helps to provide important elements of control, discussed in considerable detail previously, as well as a means of expressing and examining emotion. Good therapy will "give survivors the tools that they can use in their healing."

Support and control. The context in which adult survivors begin to do such work is one that must be characterized by a great deal of ***"support,love and patience"*** and by belief.

> ***It's important to be believed. There's still an element with this that survivors are making the abuse up.***

They need a great deal of empathic listening and understanding in a ***"safe place with safe people"***, who have knowledge and understanding of sexual abuse, and with whom they can feel ***"free of the fear of being blamed."***

> ***They need real, honest to goodness support. Someone they can call day or night who isn't going to say the wrong thing to them.***

Such people need to ***"believe in survivors"*** and to allow them to direct and control their own process of healing, since, as one therapist states it, ***"she's the expert and knows what she needs."*** Such control is itself closely tied to the experience of safety, which would seem to be a prerequisite for any therapeutic process. And survivors need to be ***"strong enough to seek another counsellor"*** if they feel dissatisfied with their current therapist.

Adult survivors: Directions and suggestions for change.

1. **More therapy**. A number of survivors commented on the fact that there ***"wasn't enough"*** and that the community needed ***"more time for therapy."*** One survivor who saw her hospitalization as playing an important role in her recovery specifically mentioned the need for ***"more beds in Unit 9"*** (the psychiatric unit), and ***"more psychiatrists"***. This is a particularly telling suggestion, given the recent public attention to the shortage of services available on this unit. One therapist noted that it appeared hospital staff were inquiring less into sexual abuse history because of the lack of resources to effectively deal with possible adult disclosures. Both the narratives of survivors and the comments of therapists suggests the need for more long term work since successful treatment can ***"generally take 1-2 years."*** One survivor noted that therapy services need more of a public

profile, since they are not easy to access, and another commented that services seemed less available than they were for her several years ago. Therapists rate the level of therapy resources in the community for adult survivors as ***"fair-to-good"***, but note that they are much less available outside of Charlottetown, and that there appears to be little for males.

2. **More trained therapists**. Therapists ratings of the level of skill and competence in the community for adult survivor treatment is also in the ***"fair to good"*** range. Survivors speak about the need for training and competence in those who provide treatment: ***"we need more counsellors who know what they're doing"***. One described current services as ***"bad...not enough and people are not trained in this area."*** Most of the survivors who had therapy reported very positive experiences with their therapists, but in one-third of those who received therapy in our sample, such good therapy came after very negative experiences with counselling.

One respondent suggested the need for ***"someone to evaluate counsellors, and a board to present complaints"*** in the light of her experience. She felt her therapist breached her confidence:

> ***She wanted me to press charges and gave my file and information to other members of my family. She made me feel violated.***

And in another case previously discussed, the survivor was sexually revictimized by her counsellor from whom she sought help for her experience of sexual abuse. Several other survivors had very negative experiences with therapists they described as unknowledgeable, inattentive and ***"intrusive and intimidating."*** In the light of these experiences, it is no wonder that they see the need for training and competence as important. This is perhaps, especially important to emphasize given the fact that so many therapists see at least some clients with sexual abuse histories. Given the emerging extent of the sexual abuse problem, and the fact that survivors appear to be seeking help in increasing numbers, the needs for training must be emphasized.

In addition to training as a basis of competence, survivors also mention the usefulness of having ***"survivor counsellors to know how she feels."***

3. Groups. In addition to the need for intensive individual work, groups are mentioned frequently as a means of addressing issues of isolation and providing support. Such groups could be directed toward treatment, or could be self-help groups and support groups. Therapists suggest the need to ***"broaden the support network"*** for survivors so that clients can help each other. Group work is seen as an especially pressing need for male survivors, and the idea of a support group for partners of survivors was also suggested. The participation in such groups needs to be under client control, since a number of those who were interviewed indicated that wouldn't like a group or could only benefit from it

when they were *"ready."*

And one adult survivor, when asked about the advice she would like to give sexually abused children, gave evidence of the considerable courage that clients must themselves provide in the process of recovery.

> ***"Stand, stand like a rock***
> ***When your courage is gone***
> ***Stand and be strong***
> ***Open your eyes***
> ***Don't let them win***
> ***Reach out and find the power within."***
>
> (A song)

IV.23 THE COURT PROCESS: THE EXPERIENCE OF CHILDREN:

> ***I didn't go to court because I didn't get my victim impact statement done because I went to my girlfriend's overnight.***
>
> Mary, age 7

> ***Court is so anti-child. It doesn't work for children.***
>
> A therapist

The court process is perhaps the clearest expression of the adult world that sexually abused children must encounter in the intervention process. Court is a game that is played by adult rules that are alien and puzzling to children, and it is played in an adult time frame that stretches into unspecified futures. Children are anxious to resolve the trauma of their abuse and get on with their lives, but the court process takes time, and children have no control over the time that it takes. At the end of this wait is the possibility of having to appear in court, a formal and intimidating atmosphere even for adults. Here, the child will have to tell a group of adults about the personal and painful details of the abuse while the person who abused her watches and listens, and will have to answer questions which she can't anticipate which may not be entirely "friendly". As a result of what these children say, the perpetrator, who may be their father, step-father, uncle or friend, may go to jail, or may be found not guilty, leaving the child confused about fundamental issues of blame and responsibility.

It's no wonder that children worry about court. Therapists speak about how the court process affects therapy and their comments reflect how much such worry becomes the center of the children's attention.

> ***Court becomes the focus. They can't think of anything else. I keep in touch with other agencies. [We] all try to do what we can to keep the kid going.***
>
> ***Nothing happens in the year of court for healing. It's all support oriented because of court.***

There seems to be considerable awareness within the intervention system that the court process is difficult and anxiety provoking for children. Extensive efforts are often made to prepare victims for court, and within PEI, no single agency is clearly mandated to do so. The recognition of this need sometimes creates considerable confusion, as in the case one therapist discussed where five different workers were involved in preparing a child for court.

There are, of course, different perspectives on the extent of this need. Crown attorneys now seem to make special efforts to interview child witnesses before the court day, a procedure that is uncommon with witnesses in other kinds of cases. Therapists, however, may feel that more preparation is necessary:

> ***Often, the child does not get enough contact with the Crown prior to a case to feel comfortable with them.***

One reflection of the extent of the perceived need for preparing and supporting children in the court process is a recent programme in Ontario (Dawson, 1991), where eight sessions were spent with children to do an adequate job of preparing them for court. It seems sobering that such attention would be devoted to address the needs and counteract the distress induced by an aspect of the intervention system, when therapists on P.E.I. usually see children less than a dozen times in order to try to help heal the wounds of the abuse itself. Considering the experiences and feelings that children have in the legal system, such attention is certainly warranted. But given the limited resources available for treatment, it raises some questions about the nature of priorities in intervention, and the relative importance of different mandates.

The legal response to child sexual abuse seems to have a major responsibility for the nature and orientation of many aspects of intervention, often "colouring" the entire process for the child. On the one hand, the intervention system must respond to the criminal nature of sexual abuse, and relations with the child will be influenced by this mandate. On the other hand, the intervention system exists to assure the abused child's safety and to help her recover from the trauma of her experiences. These two missions do not sit comfortably with each other. While therapists certainly acknowledge the importance of pursuing the criminal aspect of sexual abuse (***"It's all we've got"***), they also point to ways that the whole orientation of the process has little to do with children's needs.

> ***[In an] adversarial system, winning a case might be more important than what's best.***

Therapists and members of our advisory committee both observed that court was not child-centred, and 67% of adult survivors who responded to a question about the role of the court process in healing felt that kid's shouldn't go to court because it's ***"too traumatic"*** and ***"can be too devastating."*** To successfully balance these two conflicting mandates so that children are not traumatized and devastated by the court process is a formidable task that would seem to require a great deal of knowledge, sensitivity and understanding of the nature of sexual abuse on the part of workers, as well as maximum flexibility in the legal system of response to accommodate the unique needs of child victims. The data presented below on children's experiences of the legal process seem to reflect the fact that this balance is not being well met.

Children's Experiences in Court: The analysis of Social Services case records indicated that court involvement is common for sexually abused children. Almost half (48.7%) of the validated cases were sent to court. In 10.1% of the cases, children had to testify in court. Our interview sample had a high level of involvement with the legal system (78.6%), and 16.7% of children had testified in court. Several were awaiting court at the time the study ended.

Charges. In several cases in our sample, decisions were made to not proceed with the legal process. For Cindy, it related to issues of fear and belief.

> ***They were "going to take it to court, but witnesses got afraid of him [Cindy's father, the perpetrator] and started lying. They decided not to take it to court, because it would have been his word against mine.***

One therapist expressed concern that the Crown ***"sometimes don't proceed with a case unless they can win"***, which seems an understandable decision in the light of the long, difficult and potentially traumatic court process. But one wonders about what Cindy and other victims take the message of such decisions to be.

Katie, age 9 simply could not cope with the stress of the investigation itself. She stopped talking and hid in a corner of her room for ***"2 or 3 hours"***. Her mother relates that ***"the police dropped it because they never got Katie to say the right thing."***

In some cases, the stressful and upsetting aspects of the court process is recognized as too much for a child.

> ***The court process was begun with Cheryl, age 10, but then stopped after a month. Her mother recalls that the "charges were stayed because my daughter wasn't emotionally stable enough to go to court."***

IV.24 EXPERIENCES WITH ASPECTS OF THE COURT PROCESS: When children in the interview sample were asked if court was upsetting to them, four of the five with court experiences indicated it had upset them "a lot", while one found court not upsetting. Although the sample is small, their endorsement of the victimization and support adjectives gives some general indication of the extent of their upset: 90% of the adjectives endorsed are negative.

In order to more clearly understand the sources of upset, problems and needs in the court process, the discussion of the data will be organized around four major areas.

(1) Waiting, time and delays; (2) Preparation for court; (3) Appearing in court; and (4) Sentencing. Following that, a perspective on the role of court will be offered along with suggestions and needs for change.

(1) Waiting, time and delays.

> ***It dragged on too long. I gave up.***
>
> Judy, age 12

The experience of time is central to children's reactions to the court process. Even a relatively short period in adult terms can seem long in the life of a young child. When a member of our interview team who works with young children referred to children's feelings that the court process took too long, a Crown attorney asked her how long they would like it to take. She replied, ***"they'd like it completed yesterday."*** Four of the five children we interviewed who were involved with court found the waiting upsetting, and three reported being upset "a lot." When therapists rate how upset the children they saw in therapy were by waiting for court (N=15), the average rating was in the "moderately to extremely" upsetting range. Jim found even the month he was awaiting trial to be upsetting;

> ***I was worried about having to talk about it in court. I thought he might get off. I waited for a month and then he pleaded guilty two days before. That's not fair.***

There are several sources of anxiety and uncertainty here that are referred to by other victims as well, particularly fears of testifying and concerns about court outcome.

Presently, there appears to be little legal incentive for offenders to contribute to a rapid resolution of cases that would enable the child to avoid the anxiety of waiting and of having the abuse remain a central feature of her life. A Crown attorney noted that ***"the courts don't take into consideration the difference between pleading guilty right away and putting it off until right before trial...there are only slight differences."*** Kelly was actually waiting outside of the door of the courtroom when her father changed his plea to guilty. From the victim's perspective, and from the legal perspective as well, it appears advantageous to the perpetrator to delay the process as long as possible, and to wait as long as possible before changing his plea.

> ***The offender stalls the court process just to see if he can make the victim crumble. It doesn't seem fair that they can do that to the victim.***
>
> Sue, age 18

> ***The families and kids lose heart after a while. Maybe that's why the defense does it.***
>
> A therapist

Jason is only four years old and has currently waited three months and not yet appeared in court. His mother fears that the case may get dismissed after a long period of delays.

Sometimes, the delays in the court process accomplish just what these victims and mothers fear.

> ***For Judy, age 12, the court process was drawn out over two years. After several delays, the offender was found guilty, and sentenced to serve three months. He appealed and was granted a new trial. Judy's mother recalls that her daughter "couldn't remember the details, so the crown decided not to take it back to court. She [Judy] thought it was her fault that they couldn't take it back to court."***
>
> ***Judy herself remembers the process as taking three years and that the "judge made a mistake in the write-up so we all decided to drop it." But she also recalls that "difficulty in my memory of dates, times and clothing" contributed to the decision.***

Judy's abuse at age 9 was of relatively short duration. Over two years of court involvement have kept the abuse at the center of her life. Her mother observes that ***"she is somewhat demanding after the whole court case was over. She had gotten so much attention for two years."***

Sometimes, however, the legal process moves quickly. In several cases, charges were laid within a day of the complaint. Six year old Susan was interviewed once by the police, was not upset about it, the offender pleaded guilty right away, and Susan had no further involvement with the legal system. The entire process was completed within two months. Christie, age 4, disclosed shortly after her abuse,and was interviewed once and not upset by it. The offender pleaded guilty, Christie had no further contact with the justice system and by seven months after disclosure, her mother reported that ***"she seemed to forget about it."***

For some children and families, waiting also touches issues of safety. Tara's mother reports that while awaiting her husband's trial;

> ***There was nothing we could do to protect ourselves from the offender except lock ourselves in our four walls. The police should have stopped the offender from following us and harassing us.***

(2) Preparation for court. Several agencies in the justice system are involved with the victim in preparing for court - the police, the Crown Attorney's office, and Victim Services. Sometimes, social services and therapists may be involved in this process as well. Given the number of people who could be involved, it's not surprising that one mother thought that they ***"shouldn't have to see so many strangers to get justice done"***. The therapists felt that the children they evaluated in therapy who underwent court preparation (N=10) were, on the average, slightly more than "moderately upset" by the process.

Crown Attorneys. Three of the five interviewed children were upset "a lot" by their interviews with Crown Prosecutors, and mothers' perceptions of their children's upset are comparable to this data. Therapists voice concerns that Crowns are not ***"accessible enough"*** to children, and that the preparation of child witnesses can become rushed and ***"crisis-oriented."***

Even with good access to the Crown, the experience can be difficult for children. For Jim,

> ***Preparing for court was bad. The Crown Prosecutor grilled me three times.***

For children, the review of evidence and preparation for cross examination can touch their fears of not being believed. One therapist noted that

> ***As kids get close to court, they enter a brand new crisis for the child about what will happen. They begin to doubt their testimony. The child often feels unbelieved by the Crown after preparation. [They ask] "Was [the Crown] just acting?"***

She recounted a case of a young man who was ***"devastated by questions that raised issues of doubt and culpability"*** in such an interview.

In some cases, families raise concerns about the knowledge and experience that Crowns have with child sexual abuse. Tara's mother described her daughter as very upset in her interview with the Crown due to the lack of sensitivity. At her insistence, another Crown attorney was assigned and subsequent interviews were not upsetting to Tara. Her mother describes the second Crown as the most supportive person to them during the court process. From Susan's perspective ***"the Crown was supportive, but was not good or educated."*** Her mother felt that the Crown was not well prepared, leaving she and her daughter unready for dealing with testifying:

> *It's like a nightmare remembering that court day. I screwed up and I know it. Susan and I weren't prepared. We didn't know what was important to remember. Susan sobbed after she got off the stand 'the judge doesn't believe me, Ray [the perpetrator] is gonna kill me'.*

Ray was acquitted because of inadequate collaborative evidence. Susan feels *"It was the Crown prosecutor's fault, who didn't prepare enough for court."* Susan's mother feels that *"the Crown is stalling so far"* on the issue of an appeal, but her daughter is very ambivalent about testifying.

The whole experience has left both of them feeling embittered. From Susan,

> *He should of been found guilty - it's not fair.*

And from her mother's perspective;

> *The trial was a pathetic display of any kind of justice system. The best thing it accomplished is to show people how bad it can be.*

Susan's experience stands in contrast to other cases where children and families have felt well prepared by the Crown.

> *Jason's mother has found the Crown to be "extremely helpful. She is able to explain things to me so I understand. She met with me for over an hour at my request.*
>
> *Sue felt that "the crown was very good because I had met with her three times.*
>
> *Judy was not upset by her interactions with the Crown who she described as "soft-spoken, slow, and understanding".*

It seems that when access and time are provided to children and families by a Crown who can communicate more on a child's level, the chances for a more positive experience with preparation are greatly enhanced.

Therapists were somewhat varied in their views of the impact involvement with the Crown's office had on children. with the average rating resting close to the midpoint (neither positive nor negative). However they felt that the protocols and procedures in the Crowns' office were not particularly sensitive to the needs of child victims, especially with very young children. They were more positive about the quality of sensitivity of the workers. Several commented very positively on the recent appointment (Spring, 1990) of a special Crown prosecutor to deal with sexual abuse cases, and on the change in sensitivity of response, and the improvement in knowledge of sexual abuse since that time. Many of the positive child and family comments also refer to this one Crown. Shortly before the end of this study, however, she took a leave of absence, leaving the Crown's office without a "specialist" in the area of sexual abuse. While a new person has been appointed in her absence, this reliance on a single person or two reflects problems that need to be addressed in other aspects of the service system as well (e.g. police investigators, social workers, therapists). While there is a clear need for "specialists" in working with sexual abuse in the Crown's office and in other agencies, there must be a good level of training for other workers to serve as a "back-up" so that victims and families are always working with trained and knowledgeable individuals.

Victim Services. This agency works with victims in obtaining victim impact statements for use in court, and in doing direct court preparation and providing support with victims and families. One therapist commented about not being sure ***"where they fit into things"*** because of the number of other kinds of workers who might be involved in court preparation. Other therapists relied on them as much as possible to do court preparation.

Three of the five interviewed children were "upset a little" in preparing their victim impact statements while one was "somewhat" upset. Generally though, the views of children, families and therapists are quite positive. Therapists see the workers as sensitive to children and knowledgable and see their impact on children as above "moderately positive".

> ***Always been responsive to my request that they spend more time with kids.***

Children and their families seem to feel well supported by this agency, and several comment on the nature of the usefulness of the information they received. Parents interviewed whose children went through the court process cite Victim Services as their most common source of support. On occasion, however, it is not clear how much a ongoing support Victim Services provides to clients as they continue through the process.

> ***Victim Services helped [my daughter] prepare a victim impact statement. That helped her a little bit. Victim services helped at the beginning. Not much is offered to victims to help them, it's more to help the justice system.***
>
> The mother of Mary and Dana

Lisa's mother also commented on the lack of emotional support for her daughter during the court process, and reacted quite negatively to her daughter being addressed as a victim.

> ***Victim Services sent information with "Victim Services" on the envelope in Lisa's name. This was very harmful to us.***

Support. It is not always clear who has the most direct responsibility for providing support to children and families during the court process. It seems quite informally distributed, and for some families and children, the level of support is experienced as insufficient. In some cases, Victim Services and/or the Crowns support the child and family. In other cases in our interview sample, children and families describe being supported through the legal process by police officers, social workers and therapists.

> ***I see the police officer frequently. He stops over for a coffee sometimes just to see how I'm doing. I always feel believed and supported.***
>
> Sue, age 18
>
> ***My worker still comes over once a week. She came to the preliminary hearing. [The workers] go right through it. They do everything. The police officer [was my main support]. He lets me know what's going on.***
>
> Amy's mother
>
> ***[My therapist] helped us by talking about the questions, where we'd sit, showing us the dolls so we'd know what we were getting into.***
>
> Kelly, age 18

In Jim's case, he felt supported by the police officer who was the same one who had conducted the initial investigation.

Having diverse sources of support available for children and families as they go through the stress of the court process is very valuable and meets an important need. However, it is very important that there be clarification about which agencies have the responsibility for different aspects of preparation and support. In doing so, it would be useful to distinguish between preparation for testimony, meeting the informational needs of clients and families, and providing ongoing emotional support.

(3) Appearing in court. For children, it is difficult to separate the actual feelings

about appearing in court from all of the anxiety involved in anticipation of court, and the process of waiting. The anxiety involves more than fear about testifying. Children are also worried about having to face the offender again, and about what he might do. When it comes to testifying itself, they tend to say that it upsets them "some" or "a lot", although one child was "not at all" upset by her appearance. Therapists saw their children in therapy who had to testify (n=5) as close to" extremely upset" by the experience.

For some children, the fear and stress of court stops them from testifying. Charges were stayed in Cheryl's case because she wasn't emotionally stable enough to go to court, and Jane recounts

> ***I knew that I might have to go to court but I said I wouldn't go on the stand and talk about it. I guess I was never prepared for court because we figured Dad would plead guilty.***

One therapist pointed to the vulnerability that children would feel in having to testify.

> ***They feel like they're on trial; the question of their credibility. [They feel] that anything about their lives and families could be exposed.***

Often, their anxiety and upset about court center around facing the offender again. Sue recalls.

> ***In court, the most uncomfortable thing I felt was my brother-in-law trying to stare me down.***

For some, the arrangements in court create considerable stress. Tara's mother recounts:

> ***The courthouse is set up so that she had to sit directly beside him [the offender] - this is very intimidating.***

It is very helpful to victims and families when the difficulty of such arrangements are recognized. It was very important to Susan that ***" the Crown Prosecutor let us sit in the back behind the court so we didn't have to face the offender."***

The small number of interviewed children who appeared in court commented only sparingly about their direct experiences with defense attorneys and judges. Their reactions are mixed with two children feeling the judge ***"really helped"*** and one indicating the judge ***"made things a lot worse"***. Children and families also have a lot of feelings about sentences, but since in most cases, they never appear in court, it is difficult to evaluate their perspective on judges. While one angrily referred to the judge quite derogatorily another child commented that the judge ***"wasn't like a judge. He acted very human. He was very patient with everyone."***

Experiences with defense attorneys are generally moderately negative. One therapist expressed concern that there seemed to be ***"no ethical standards for examination of child witnesses - the adversarial method doesn't work out well for kids."*** Cross examination can be very difficult for children.

> ***The defense lawyer was rude, loud, and made me feel responsible.***
>
> Judy, age 12

> ***We didn't know that his lawyer is allowed to browbeat and make fools of us.***
>
> Karen's mother

Therapists see significant problems in the level of sensitivity of the court to children's needs and see a considerable need for greater education of court personnel. They raised concerns about how receptive judges are to expert testimony meant to inform the court about the dynamics of sexual abuse and their willingness to get training. They also raised the issue of whether some judges even see sexual abuse as a serious crime.

Most specifically directed to the experience of children in court, concern was expressed that the stern demeanour that judges present in court, was very intimidating and scary for everyone. One therapist concludes that there was no reassurance she could offer to children about how judges would respond to them in court. ***"This is the hardest part of the journey for kids. [There are] simple ways it could be made easier."***

(4) Sentencing

> ***Their therapeutic future is in doubt. If the case is lost, then how will you reframe this for the kid?***
>
> A therapist

> ***I was waiting outside of the door of the courtroom when he changed his plea to guilty. He got weekends for a couple of months. Can you believe that? I was so pissed off. We were being punished more then he was. The whole thing made no difference. It was just a waste of time.***
>
> Kelly, age 18

What awaits children at the end of this long legal journey? In many cases, the court decision is the end of the intervention process, and has a strong impact on their feelings. It offers the possibility of an affirmation of their status as a person who has been abused and violated, and a confirmation of their being believed and vindicated from any responsibility for what happened to them. Or it can cast doubt on that status as a victim, or communicate that their victimization is not serious, or that others count more than they do. One third of the adult survivors who responded to a question about the relationship between court and healing felt that court could help victims recover under certain circumstances. One says that it is ***"a vindication to see the offender brought to justice"*** and another comments that ***"stiffer sentences could be healing for kids."***

Within our interview sample of children and families, there were court decisions in 13 cases, while four cases were pending at the time the study was completed. Of these 13 cases, there were 12 convictions and only one acquittal. Of the convictions, half the perpetrators were sentenced to time in jail, while the other half were given probation (with treatment in all cases but one). The sentences given as identified through the interviews are listed in Table 4.2

TABLE 4.2
SUMMARY OF COURT SENTENCES

SENTENCE
6 months, 2 years probation
3 months, (served 2 1/2)
3 months
3 months - appealed. Crown dropped case
3 months (served 2) + 3 years probation + treatment
"Weekend for a couple of months"
1 day in jail, 1 year probation
1 year probation + therapy
Probation + counselling
Probation (3 years). Appealed. Sentenced to 3 months.
Acquitted
Probation - 3 years
Probation (2 years) + treatment

Reactions to sentencing.

> ***The perpetrator gets off way too easily. In certain cases, perpetrators should be put in jail for life - it's like murder.***
>
> Jane, age 15

Parents were asked if their children were "happy" with the verdict. In 9 of the 13 cases (69.2%), they reported that they were not, and most of the parents (76.5%) were unhappy with the verdict. As the quotes above indicate, the sense of outrage that many of our respondents felt was profound. From their perspective, the damage to their lives was deep and the crime against them was very serious. The legal response seems grossly inadequate to them. In even fairly young children, their sense of justice may be offended.

> ***He had to go to jail for about two months. That wasn't fair. He should have gone to jail until he told what he did.***
>
> Jennifer, age 9

Anger over light sentencing is the predominant reason for the children's and parents' upset at court dispositions, and a number of them focus on their sense of justice. They weigh what they have been through as victims and with victims, and perhaps in the court process, and compare it with the legal response to the perpetrator. They sense a lack of balance.

> ***[Bob] was very angry and says it wasn't worth it. They go through all that, and empty their guts out to strangers, and the offender gets off too easy. I was angry because the sentence didn't fit the crime. You get more of a sentence for stealing a car than for ruining someone's life through sexual assault.***
>
> Bob's mother

> ***I felt we went through so much for nothing for two years.***
>
> Judy's mother

Children are also upset with dispositions because they feel guilty, and blamed.

Tara was ***"extremely angry and hurt. She felt she was accused."*** Susan was ***"disgusted and feeling that it was all for nothing, and felt like she was not believed."*** For several other children, their unhappiness stems from feeling guilty and responsible for what happens to the offender, and to the family. Karen ***"blamed herself for her father going to jail."*** Like the dynamics of the abuse itself, the encounter with the court system often leaves children feeling guilty, powerless, and angry. For two of the mothers, their upset had to do with the perpetrator being imprisoned. Janet's mother was eight months pregnant, and she ***"couldn't understand what jail could do for him."***

In addition, some of the families often express concerns about safety in the light of the sentence. Tara's mother, whose husband was sentenced to one day in jail, is ***"afraid he'll come after us again."*** Jim felt ***"really safe when [the perpetrator] was in jail, but he's out of jail now. He's somewhere else on the Island and it scares me that he might be hurting other kids."***

IV.25 SUGGESTIONS FOR CHANGE: It is evident that there are profound problems in the court system. When children are given "three wishes" to address what needs to be changed most in the response to sexual abuse, 36% of their suggestions have to do with court, far more than any other area of concern. This is especially revealing when one considers that several children had no court involvement. Six of the eight therapists interviewed also identify court changes in their several priorities for change. In the suggestions of children, families and adult survivors major themes are as follows.

1. **Heavier sentences for offenders**. This has been discussed at length, but one adult survivor's perspective on justice and impact is worth adding here:

> ***[Sentence should be] the same number of years in jail as he has wasted in their life.***

2. **A speedier process**. This has also received considerable attention, but one mother adds the suggestion that ***"the verdict should have been handed down immediately after the case is heard."*** This suggestion contrasts sharply with the experience in one case, where a mother reported that the judge deliberated for six months before determining his sentence.

3. **Change court procedures to make them more sensitive to children**. Many specific suggestions are offered on how to make appearance and testimony easier for children. Survivors offer some ideas about how children may be able to avoid appearing (***"Lawyer should stand for the child; Crown should be able to enter the facts"***). As well, the groups offer suggestions for closed court, ways of avoiding contact with the offender, more comfortable contexts for children, and suggestions for testimony. Judy, age 12, had only one suggestion.

> ***"More tissues".***

4. **A sensitive and fair hearing.** Some mothers make references to their perceptions of bias in the judgement of cases.

> ***Politics and religion should stay out of the courtroom.***
>
> ***Make sure there is no connection between the judge and the people in the case. Judge had decided to put him in jail no matter what the lawyer said.***

For children, their sense of fairness had to do with their feelings that they had to bear the brunt of errors and lack of preparation by court personnel.

> ***If the Judge makes a mistake, it's not her [the victim's] fault; she shouldn't be punished.***

Consistent with this concern are adult survivors' suggestions for more education and training for court personnel.

5. **Better court preparation**. Families want to know what to expect, and have more communication with the police and courts, and to generally receive more information.

6. **Address the general systemic problems**. Some of the suggestions of the adult survivors focus on what they perceive as the deeper sources of some of these court problems. They observe that the ***"defendant seems to have all the rights"*** and that the ***"court is controlled by men who do not really understand sexual abuse"***.

One therapist, when commenting on just how difficult court is for children, and how they could be prepared for court commented that

> ***Nothing prepares you for being badgered in cross-examination, having a charge dismissed, or a short sentence...it just destroys them.***

In the light of these difficulties, it is no wonder that one adult survivor suggested the need to

> ***Create a new system. This one is not working.***

IV.26 SOURCES OF SUPPORT FOR CHILDREN:

Experiences in families. The presence of a supportive and helpful response in children's families can play an important role in ameliorating the effects of the abuse. As data presented previously indicated, the response to disclosure by mothers and non-offending fathers is generally supportive, and continues to be supportive as time goes on. From various sources of data including therapists and social workers ratings, it appears that mothers and non-offending fathers are very supportive to children in 70-75% of the cases. Children's perceptions of helpfulness are consistent with this conclusion, as mothers are rated as having "really helped a lot" through the entire intervention process by 72.7% of the respondents. Fathers are rated similarly by 5 of the 6 respondents for whom they were not offenders. Furthermore, when the most important sources of support were identified for each child by project interviewers, parents (either moms or moms/dads) were identified as the most frequent source of support.

As indicated earlier, siblings' responses to the victim appear to be more mixed. Only 20% of the children indicate that their brothers and/or sisters "really helped a lot", and they are identified by interviewers as important aspects of the support network in 23% of the cases. They are, however, generally seen as helping " a little" in another 60% of the cases. This finding is supported by caseworkers ratings of siblings as a source of support 60% of the time. Children indicate that other relatives "really helped" in 58.3% of the cases. Interviewers identified this group as central to the support network somewhat less (38.5%), and caseworkers saw them as playing a supportive role 47.1% of the time.

In those approximately 25% of the cases where family support is problematic, the results can be profound. Cindy, age 16, recounts the reaction in her family after her abuse by her stepfather became known, she was rejected by her family when she disclosed her stepfather's abuse. She had to move from her home and still lives with the parents of her best friend who she regards as her most important source of support. Such cases represent a significant area where sensitive support must be provided to children.

Experiences in the community. A child's personal pain can rapidly become a very public fact, and the disclosure discussion introduced some examples where the responses of persons in the "community" had a significant impact on children. There are two aspects to be addressed here: (1) sources of support in the community; and (2) the impact of a child's abuse being known, including children's concerns about their abuse becoming public.

Children identify their friends as an important source of support to them. Generally, the children we interviewed have been very cautious about who they tell, and some tell no one for fear of others' reactions. When they do tell, their experiences are

more often positive, and 63.6% of respondents indicate that their friends "really helped". While interviewers identify friends as key support resources in only 23% of the cases, most children's experiences with friends do seem to be clearly positive.
When this is not the case, the betrayal and hurt that children feel is evident:

> ***My ex-best friend told everyone and I told her not to tell. Some kids at school don't like me.***
>
> Katie, age 9

The other most common source of "community" support for children appears to be their guidance counsellors who are identified as key support persons in 23% of the cases.

It is difficult to very clearly describe the kinds of experiences that children have in the community once their abuse becomes known. Parents report that people outside the family almost always learn about it (92.3%), and that they believe that the child is very often treated differently (58.3% of the cases) as a result, although such different treatment is often supportive. It appears very important to children to try to control the flow of information about their experience because of their concerns about how others will react, and because of their feelings of visibility when other people know. Even though Susan tried to keep her experience to herself:

> ***I feel like everyone knows what happened. They are looking at me and know what happened.***

Cindy feels very supported by friends and teachers, but very uncomfortable with the widespread knowledge of her abuse, even though the people who know are trying to protect her.

Besides the general discomfort with such public visibility, the negative consequences children fear should their abuse become known sometimes take place. Jim's abuse was widely known in his community. Although people were generally supportive, shocked, and angry at the perpetrator, Jim was very upset by being teased by his peers at school. In Judy's case, her friend's parents wouldn't allow them to come over to her house to play after the abuse became known.

In a small rural place like Prince Edward Island, it is very difficult to control the flow of personal information. Children's loss of control over this personal secret becomes yet another victimizing experience of vulnerability and powerlessness. And while all steps possible should be taken to limit knowledge of the child's abuse by others, given the rural realities of P.E.I., it is imperative that public education about sexual abuse direct attention to influencing the reactions of others, so that the child's difficult journey is not made still more arduous.

IV.27 SOURCES OF SUPPORT: A SUMMARY: Of course, the helpers in the intervention system are a key aspect of the social response to victims and part of their potential support network. And children generally do identify such workers as being very supportive to them. Many children felt that they were "really helped a lot" a substantial amount of the time by therapists (66.7%), social service investigators (54.5%) and police officers (50%). And while the numbers with experiences are considerably smaller, the majority of respondents identify their experiences with caseworkers (3/5), victim services(4/5), foster parents (3/3) and judges (2/3) as helpful.

When the key elements of the support network identified by interviewers are analyzed for all child respondents, it is interesting that half of the persons identified are professionals and helpers, while the other half are family and friends. Among the helpers, therapists were cited most frequently (6 times), followed by social workers and guidance counsellors (4), group home workers and police officers (2), and foster parents and school principals (1). Among family and friends, mothers are the persons most commonly mentioned (5), although in other cases parents are identified (3). Other relatives are frequently identified (5), followed by friends (4), brothers/sisters (3) and family friends (2).

It is apparent that children have many "natural sources" of support in their worlds that help them in their struggle with their abuse. An intervention system should utilize these natural sources as much as possible, and find means of developing them further, in addition to providing sensitive and knowledgeable professional sources of help for sexually abused children.

IV.28 CHILDREN'S EXPERIENCE OF THE INTERVENTION SYSTEM: A SUMMARY

> ***I've never seen a kid who's gone through the system who can say it's never hurt her at all, or that it's been particularly worthwhile. It's tough being part of a system that has this effect. You pick up the phone and set the wheels in motion that will hurt this child. [Your] only comfort is in knowing the people that you send kids to...people who can insulate the kid from being as strongly affected.***
>
> ***(If you were a victim, do you think you would disclose?) Probably not. I'd have to tell my story so many times, dad taken out, strangers interviewing me, the court process. Treatment and help is rare. I'd shut up.***
>
> ***I would... and I'd hope for the best. Sometimes it has been healing and helpful. It's still better to tell.***
>
> Three therapists

When therapists think about the impact of the entire intervention process, they are very ambivalent about its helpfulness to victims. When asked if they thought that the system revictimized children, or whether they would disclose, none could give an unequivocal yes. Even the last therapist cited above felt that the intervention system ***"very often"*** revictimized children, but ***"not always."*** Another estimated that children were revictimized ***"85% of the time at some stage"***, while another responded ***"definitely."*** Several workers felt that ***"it all depends"*** on the workers you get and/or on the nature of familial support. One of the more optimistic therapists, who didn't know if she would disclose herself, put it this way:

> ***I can certainly understand why people don't disclose and why they regret it. I certainly have had clients who feel they were worse off. But even in the [terrible] cases, there's always elements of a positive restorative process.***

On the whole, when our small sample of therapists ranks how well the overall intervention system is meeting the needs of sexually abused children they indicate that only a ***"fair"*** job is being done. For families, they are even more dissatisfied, with the mean ranking being close to , but somewhat above ***"poor"***. Currently, the intervention system is seen as having close to a ***"slightly positive"*** impact on children, while its impact on families viewed as ***"neither positive nor negative"***.

There appears to be a great deal of uncertainty regarding the effects of intervention. "It all depends" on too many contingencies outside of a child's control. Perhaps if the child is interviewed sensitively and briefly by one of the several police officers who are so frequently mentioned as excellent, and by one of a number of skilled social services investigators , and the offender pleads guilty right away, allowing the court process to be brief and not involve the child, and the child is able to see one of the several therapists who work well with sexually abused children, perhaps then, if the child's family is basically supportive, and the abuse has been of a relatively short and less intrusive nature and the perpetrator is not a family member or someone in a position of trust, the outcome and its intervention on the child will be positive. But clearly, there is a great deal of variability in the current system of response. To feel safe, children would have to be able to count on it, and currently, it is very unpredictable. Children cannot know what is going to happen. They have to "take their chances and hope for the best". It's a gamble.

From the perspective of most children we interviewed, most felt that the gamble was worth it. All but one indicated that they felt helped by the intervention process, and indicate how it helped to stop the abuse. They know they must disclose to get help and they want help to stop the abuse. Generally, they indicate that they would disclose again, but Cindy only says ***"maybe"*** and Sue says ***"no"***.

> ***I wouldn't tell again. Because the system doesn't cater to the victim. I hadn't realized what it all entailed. I'm still not sure that he will get any more than a slap on the wrist.***

In their advice to other kids who have been sexually abused, our sample of children emphasized the importance of telling and talking about it. This is the only road to safety. Unfortunately, in its current form, the road itself is far too precarious for children.

Children's Intervention Needs:

The interviews with children and families, and the other data and perspectives that have been presented here, have identified a number of problems and needs associated with all aspects of the intervention process. Behind these problems and needs are children who may feel powerless, stigmatized and betrayed in their experiences with the processes and the persons that are present to help them. These feelings are at the core of the experience of victimization, and to the extent that these feelings are touched in children in the context of relations with the intervention system, their victimization continues. Within the adult survivor sample, even the ultimate revictimization occurred to three women who told of their disturbing experiences of being sexually abused by persons who were part of the system designed to help them.

The first aim of intervention should be to do no harm. Our findings suggest that the first need to be addressed in a model of intervention is to acknowledge that this is too often, not the case. Once there is such an acknowledgement among all the agencies that respond to sexual abuse victims, then methods need to be developed that provide workers and agencies with ongoing feedback about children's experiences, and means developed to address the sources of children's feelings of revictimization. These sources appear to exist on several levels; (1) mandates, protocols and agency practice; (2)knowledge, experience, and training; and (3) issues of worker sensitivity. To successfully assure that the system does no harm, it is essential that problems on all these levels be examined and addressed.

To counteract the experience of victimization, children need to be have a sense of safety, support and control in all aspects of the intervention process. Children need as much support as possible in coping with the crisis that disclosure brings to their lives, and with the difficulty of intervention. The "natural resources" in their families and communities are valuable sources of support(e.g. mothers, relatives, friends, guidance counsellors, the person to whom the child discloses). These existing networks should be utilized and strengthened as much as possible in providing the basis of a renewed sense of security and an atmosphere for recovery. New opportunities for helpful relationships also need to be developed, such as support or self-help groups. Giaretto (1982) has developed a range of support and self-help opportunities that may provide useful ideas for a model.

While support systems are a valuable means of helping deal with the crisis of disclosure and the whole process of intervention, therapeutic opportunities more specifically directed toward helping the child to resolve her abuse, and move toward greater self determination are required. There is a need for intensive individual work as well as groups for different ages/sexes of children. Children's control over the therapeutic process is an essential aspect in recovery, and opportunities need to be provided that are at a child's level and pace. Finding ways of integrating supportive and therapeutic resources would seem to be very beneficial to children.

So much of intervention with children understandably canters around the need to protect them. It is imperative that the first priority in intervention be the assurance of children's safety from further abuse. But the findings of this study suggest the strong need to balance the attention to safety with the need children have to control their lives. This is especially true with sexually abused children. For these children, powerlessness is at the heart of their experience as victims. A statement of the philosophy of the National Youth in Care Network offers an approach that also seems well suited to meeting the needs of sexually abused children.

> Empowerment is a priority for young people in care. It must be recognized that the best care is not necessarily that solely endowed on us from above...rather, the best care must be viewed as a process in which both service providers and service receivers share the decision making and the responsibility involved. We must become more involved in the design, implementation, operation and evaluation of the services which affect our lives.
>
> ... Consumer feedback and evaluation on the part of young people in care must be incorporated as an essential component of all child welfare services. Those with the most pertinent insights into the adequacy of child welfare services are the youth actually receiving these services. As such, all youth in care must be encouraged to 'speak out' on their own behalf. A higher quality and more efficient child welfare system will be the results (Raychaba, 1988)..

It is apparent that children first require a voice in the system of intervention. They need to be able to voice their reactions and discontent, to speak about and identify their own needs, to participate in the decisions that affect them personally and collectively, in their "cases" and in "policy". The opportunities need to be created within the intervention system where these voices will be welcomed and heard. Initially, it would seem helpful to find various ways of amplifying children's voices since children's voices may be hard for adults to hear. Sympathetic adult advocates, or groups of children may be useful in this process.

Placing the child's experience at the center of our report is one means of giving children such a voice, and to begin to organize our intervention around how they define their own needs and problems. But it is imperative that if children and victims are asked about their experience, then we must be prepared to carefully listen and respond to what they have to say, however difficult it is for us to hear.
And even though many of the problems in intervention that children and families speak about in their interviews are very similar to those identified by the professionals themselves (e.g see the Advisory Committee "problems" list in the Appendix), such "feedback" about clients experiences still may be difficult to hear.

Two aspects of our interview experiences with children and adults survivors are relevant to this observation. We asked children about their experience of being interviewed, and all of them gave responses that ranged from neutral ("OK", "not bad") to positive ("it's been good", "really good"). But, in spite of all attempts to provide a supportive context, there was one child who, we learned, had been upset by the interview when a concerned interviewer called her mother the following day. In another case, the bureaucratic organization of our large and complex project (much like the intervention system itself) led us to respond to an adult survivor who was volunteering her help in an impersonal and insensitive way. She was angry, and felt manipulated and revictimized by us, and wrote to us about it. That was difficult for us to hear, but very important for us to hear, and hopefully, it sensitized us more in our responses to those we interviewed. Much of what has been suggested by children, adult survivors, and now, by the research team in this report, supports and encourages such an expression of client feedback, as an important means of identifying and solving the problems in intervention and learning what clients need.

The essence of what is needed is the development of a system of response centred around the needs and experience of children. To accomplish this, the child's voice must now be given more weight than the voices of powerful adults with their own agendas in the child's life. This is the basis of empowerment and recovery.

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V. NEEDS AREAS - FAMILIES

The study was interested in collecting information concerning the needs of victims of child sexual abuse as they related to the interaction of their families. A system which is concerned about support and healing experiences for the victim must take into consideration the needs that the family presents. The study was interested in understanding the family factors which have the potential to positively or negatively impact on victims.

The nature of abuse (either intra- or extrafamilial), the particular strengths or problems within the family system, as well as the support system around the family can all be factors which will impact upon the family's ability to provide a supportive relationship to the victim. Many of these factors will be conditions which have existed previous to disclosure. This study was also interested in understanding processes that can have a positive or negative impact upon victims once disclosure occurs. Some authors have examined the role of the family subsequent to abuse. Adams-Tucker (1982), Schultz (1973), Rogers and Terry (1984) and Simrel, Berge and Thomas (1979) all found that parental response had a major effect on the trauma of the abused. Schultz (1973) goes on to say, "It is clear from cited child sexual abuse victims that it is not the sexual assault that usually causes trauma but the child's parents' behaviour upon its discovery" (p. 150). Conte and Schuerman (1987) found that the level of social support available to the child after the abuse and the presence of a supportive parent or sibling reduced the negative effects.

Other authors have written about the issue of the potential for divided loyalty within families once disclosure is made. "If the victim is misunderstood or blamed, or her point of view is rejected, another experience invalidated, the most damaging effects of abuse are reinforced rather than ameliorated" (Courtois, 1988, p. 33). The issue of divided loyalties is discussed by Sgroi (1985) and is seen as a primary area of conflict in providing proper support to the victim. The interaction and the level of support that can be received by a victim of child sexual abuse seems to be vital in that child being able to make it through the process of healing. A number of authors (Estroff, 1986; DeJong, 1985) have examined the process of adjustment in families concerning support for the victim. The victim needs acceptance and validation (Trepper, 1986).

Sgroi (1985) discusses a number of factors important at the time of disclosure to determine the level of supportiveness such as reaction of the family to disclosure, past history of supportiveness and reliability towards the child, present attitude towards the child including issues of believability, concern, and volunteered support, and family attitude towards the perpetrator.

In particular, in the area of father/daughter incest, the role of the mother appears to become extremely vital. "The mother's choice is crucial to the daughter's recovery" (Herman, 1981, p. 88). A number of authors (Herman, 1983; Hoorwitz, 1983) have identified the vital role of mothers in providing adequate and ongoing support to the victim.

It is recognized that the response of family members is extremely vital in regards to the effects on the victim. At the same time, the ability of the family to provide a helpful experience to the victim depends upon the resources within their family system as well as the support that they receive as they go through the various processes from disclosure to treatment. This study was interested in understanding those processes and being able to define the needs of families that must be met so that they can provide for positive, helpful responses to victims.

Sgroi (1985) identifies a number of important services that are required for families including essential life-support services, e.g., ongoing and emergency shelter, money, food, clothing, and day-to-day help in carrying out activities of daily living. She states that immediate availability of these services can assist bewildered members in resisting temporary dependency during a period of striving for a greater independence. This may require vigorous outreach and concrete services especially to mothers in the area of child sexual abuse.

Sgroi (1985) has noted the need for families, both in intrafamilial and extrafamilial abuse, to receive some form of treatment. At the same time, Haugaard and Reppucci (1988) caution against this in all extrafamilial cases and suggest that in some cases treatment may be detrimental to the victim if the family is erroneously perceived to have had some blame for the abuse.

Even though there may be some debate concerning the exact nature of intervention required in families of child sexual abuse, it appears that families require some level of support.

The concept of support as an important variable to ameliorate the effects of traumatic situations has been studied from various perspectives. Authors have studied this from various levels within the social system including primary kin, secondary kin or extended families, friends, neighbours, and work acquaintances (Mitchell & Trickett, 1980). Some of the functions of a healthy support system are concern, assistance, emotional support, task assistance, sense of belonging, advice, feedback, material aid, maintenance of identity, access to new contacts, attachment, a sense of alliance, reassurance of worth, and the opportunity to provide nurturance.

Some studies have examined the importance of support systems as they impact upon individuals' and families' adjustment to distress and trauma. Trute and Hauch (1988) examine the social network attributes of families with positive adjustment to the birth of disabled children. The study demonstrated that positive adaptation was related to support by small, well-organized human networks. At the same time, this adjustment was attributed to skilful parental coordination of a small, intense human network of extended friends and family.

This raises a major question as to how families of sexual abuse victims, and especially incest families, are able to organize such a support system. This is especially problematic since the families of incest victims are often reported to be isolated from communities. Trute and Hauch (1988) identified that almost without exception mothers stated that the majority of their closest contacts were other women, often long-term friends. Mitchell & Trickett (1980) suggest that the psychological climate of the family and the level of family social integration into the community are hypothesized as being related to the size and quality of the client's social network. An isolated individual within an isolated social system would seem to have minimal opportunity for increased social network support. In fact, the degree of support clients report exchanging with peers appears to be related to the emphasis on autonomy within the family and the family members' perception of having support from other relatives.

Therefore, there is need to understand not only the nature of social support systems but also supports within the family. In a study to assess the role of family relationships on the impact of combat-related post-traumatic stress syndrome (Solomon, et.al., 1987), it was found that the extent to which family members support and are involved with one another reduce the effects of combat stress reactions resulting in less symptomatology on PTSD.

As such, this study will be interested in examining the level of support that a victim is able to receive from (1) his/her family, and (2) his/her social environment. To determine that, it is necessary to understand the nature of relations within the family as well as the support systems available to that family. Recognizing that a family of a child sexual abuse victim is going to experience major stresses once disclosure occurs, whether the abuse is intra- or extrafamilial, it is necessary to understand the impact of the intervention of the system on the family and indirectly on the victim.

There has been little systematic research based on the impact of the social systems intervention on the families of victims of child sexual abuse. Rivera (1988) studied 14 families' interactions with various social systems in the investigation and management of cases of child sexual abuse in Toronto. The families generally felt supported by police and child welfare personnel in protecting their children from further abuse and many of the parents and children received help to deal with the abuse. However, the court system was perceived to be extremely inadequate in securing justice and protection for victims of child sexual abuse, particularly those under the age of eight. There were also information/communication/support gaps perceived in the investigation and management of the cases in which the professionals were perceived by families as withdrawing much of their involvement and support while the family was still in crisis.

The concept of support is one which involves interaction of the process of "giving" and "receiving." This process includes a "behaviour or an action" as well as an "intention." The giver may offer help and intend to be helpful, and the receiver may get help and interpret it as helpful. This is the most congruent interaction in the therapeutic process of support. Different types of support include emotional, material, advice and information, physical assistance and participation.

The study attempted to understand the stressors and resources that a family brings to an abuse situation that will impact on its response to the victim. As such, the study is interested in understanding the concept of support (1) between the family and the victim, (2) between the family and the social intervention, and (3) between the family and their formal source of support system. The impact on the victim is viewed as an interactional process in which support is derived from a direct and indirect fashion to the family.

A number of changes had to be made in the data collection and measurement process over the concepts identified. The reason for the change is identified earlier in the study.

V.1 DATA COLLECTION

Data collection on the needs of families was obtained from a number of sources. These included the following:

1. Key informant interviews with 26 families of victims of CSA who have gone through or who are in the system. As well, 9 victims in these families were interviewed.
2. Information from Child and Family Service workers on 79 victims and their families in the system from 1986 to 1989.
3. Information from CFS workers on 90 victims and their families in the system from July of 1990 to May of 1991.
4. Information from therapists.

V.2 ASSESSMENT INSTRUMENTS

In addition to the instruments detailed in the Methodology Section, the General Functioning (GF) subscale of the McMaster Family Assessment (FAD) was administered to 26 families. The GF scale has been used in other studies such as the Ontario Health Study to measure family functioning and it has been found to be a suitable instrument which can be used with reliability and confidence to identify scores of general family functioning.

V.3 FAMILY INTERVIEWS

Trained interviewers met with 26 families, in which all but 1 of the informants was a mother. The interviewers went through the experience of the family from pre-disclosure through the disclosure process, to investigation first by police and then Child and Family Services (CFS). The interview then moved into the intervention process by CFS to court and then into the therapy experience. Therapy was broken down into victim, respondent, family and perpetrator therapy. The interview guide also asked information about the role an support from friends, extended family and community. The guide was set up to allow for rating of various experiences as well as open-ended responses to what helped, what was unhelpful and what needs to change.

In reviewing this data, it is important to remember that these interviews were not designed as an evaluation of services. The sample was drawn by referrals from agencies and is not designed to be representative of the entire population of families, either by number, background or region of the province. At the same time the information provided by families is viewed as very valuable in giving their perspective of theri experience, what was helpful and what was needed in a model of effective services. It should also be noted that even though Moms were almost always interviewed (except for 1 father), throughout this section it the Moms who are quoted and in many situations they speak for other non-offending spouses or partners.

V.4 DATA ANALYSIS

Information on the interview was coded and entered into the computer. Frequencies were identified with some further analysis of separate populations within the sample. In addition open-ended responses were reviewed and categorized to identify important areas of need and direction for programming. All interviews also underwent a qualitative analysis by the interview team, to identify important themes and issues presented by these families.

V.5 SAMPLES

A sample of 26 families and 13 victims in those families served as key informants to the study. Twenty-five of the respondents were mothers and one was a father. Eleven (42%) were married, 6 separated, 5 divorced, 3 single, and 1 common law. Of the 26, 73% were intrafamilial abuse with 38.5% being parent abuse, 27% biological parents. Of the 26, 23% were living at home with 8% living with another relative, and 11.5% in foster homes. In 2 of the 26 cases, the perpetrator was still living at home.

V.6 RESULTS

A. Support within Family Predisclosure

The informants described their relationship with the victims as generally supportive (89%), and close (80%) while about 50% of the victims were described as having a conflictual relationship with Mom. Fathers were less of a support to the victim with only 43% described as supportive, 25% having a close relationship, and 70% identified as having conflict with the victim. Siblings of the victim seemed to be generally supportive, with 70% identified as supportive to the victim. The person reported to be the closest to the victim during the predisclosure period was Mom with 50% of the sample, followed by friends with 23%.

B. Disclosure

Respondents were asked to identify initial reaction to disclosure, some reactions identified as supportive and others as non-supportive to the victim. The Moms demonstrated 55 supportive responses to the disclosure by the victim and 5 unresponsive. Fathers demonstrated 23 supportive responses and 3 unresponsive. In cases where the perpetrator was the father, he displayed 25 negative responses to victim with 11 positive responses. For example, 15 of the perpetrators denied the abuse, with 3 being angry at the victim and 5 displaying anger at the spouse. Six perpetrators acknowledged responsibility for their actions. The siblings were more ambivalent in their response to the victim, with 7 of 17 demonstrating nonsupportive responses. The extended family displayed 16 negative responses to the victim and 20 positive.

Disclosure most often was to the mother. The amount of support that the mother was able to provide to the victim was generally good. For some even though very upsetting, the concern was quite clear. For other Moms, especially in cases of intrafamilial abuse, the disclosure created larger problems and dilemmas in their lives. Overall, Moms were often left with ambivalent feelings. One Mom stated,

> ***"I asked why didn't she tell before? I was hurt because I failed to warn her about the perpetrator."***

Another Mom stated,

> ***"I was sick with disbelief. I never thought this could happen in my family. I believed her but I was so screwed up with not wanting to believe it happened."***

Another Mom stated,

> ***" I was numb, I guess; didn't really know what to do- thought I should go to Social Services, didn't know what to do."***

Even though circumstances were difficult and the reality painful, Moms appeared to be there for their children.

A number of open-ended responses indicated that parents, and Moms in particular, could provide an important role in the process of assisting children to disclose sexual abuse. Therefore such things as: a) parents should tell their children about sexual abuse at an early age and b) parents should talk with their children about their bodies and physical touch.

C. Investigation

Seventy-five percent of the respondents felt that they were very helpful to the victim during investigation. At the same time, there were a number of problems identified in terms of Moms being able to supply support to their child. Two respondents felt that they should have been able to be involved more closely in the investigative process.

> ***"They should have let me sit with her during the police questioning. She would have felt safer if she could have been on my lap."***

Within family members, outside of mothers, other relatives demonstrated clear support of 53%; siblings at 33%. Moms continue to be identified as the main source of support through intervention and the court process. At the same time, respondents identified problems concerning access to information about the court process, and an inability to intervene and support the child during this period.

A qualitative analysis was done on each family interview and the interviewers rated the level of support available to the child from the family. The rating scale was from 1 to 9 with a rating of one being extremely helpful/supportive and a rating of nine being extremely unsupportive. Fourteen of 18 responses were in the range of supportiveness with 3 responses being in the unsupportiveness range, with the highest rating of 1 at 7. In reviewing the analysis of support by parents, the qualitative process identified that in almost every situation where there was low family supportiveness, it was more related to extended family reactions of the parents or brother/sister of the perpetrator or, in some cases, ambivalence among the siblings. In most cases, mothers were identified as quite protective and supportive of the victim.

V.7 INTERVENTION SYSTEM - SUPPORT TO MOTHER

The study was interested in getting an understanding of how the intervention system assisted the mother and family in supporting the child and also what supports are necessary to assist mothers and families to accomplish this.

A. Support to Mothers by Agencies

Investigation

Through the open-ended questions, mothers identified a number of things that were helpful, some of the things that were unhelpful, and made a number of suggestions for changes related to assistance to them to provide support to their child. During the investigative process, Moms thought it was very helpful when: a) she was listened to; b) when she got the feeling that certain agencies such as police were more like friends; c) that there was support from agencies especially in allowing Moms to have a say in things and to be involved.

One Mom stated,

> ***" The police officer helped because I was able to talk to him as a father with feeling. He wasn't offensive, didn't make me feel guilty."***

Another Mom stated,

> ***"The social worker was really good to me. She even came to work to see me. It was as good as it could be."***

Moms also found some things unhelpful and reported feeling that they were being blamed and made to feel guilty for what happened. One Mom stated

> ***" No one really helped. When I first reported, they asked whether I wanted to put my son in a foster home until things settled. How would that have helped?"***

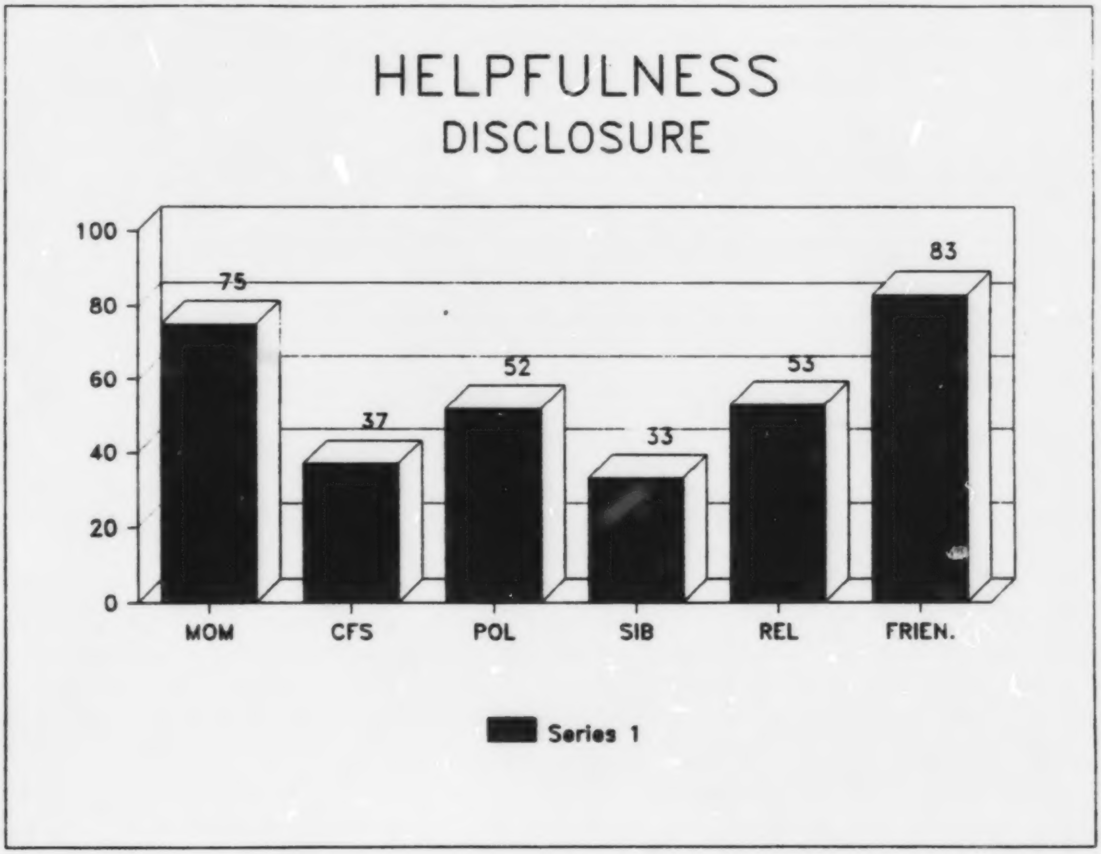
A general theme was that the child needed more support and also Moms did as well. A couple of Moms suggested an advocate or a broker to help them deal with the service system. One Mom stated

> ***" There needed to be a support person, who was not associated with Social Services to help the victim through it."***

Some mothers felt that the process of the investigation was not organized well and that the investigators could be more sensitive and trained. Other Moms felt that the system needs to deal more effectively with the perpetrator during this time. Issues of feedback, involvement, and generally more support for families focused during the investigative process.

Respondents were asked to rate the overall helpfulness of police and CFS during the investigative process. Thirty-seven percent found CFS to be clearly helpful, with another 40% stating they were somewhat helpful, somewhat hindering.Police were reported as 52% clearly helpful with another 29% reporting them to be somewhat helpful, somewhat hindering. See table 1.

TABLE 1:



THEMES IN OPEN-ENDED RESPONSES-INVESTIGATION

HELPFUL TO YOU	UNHELPFUL TO YOU
I was able to help my child	Process poorly organized
Someone was there for me	Lack of preparation for victim
Allowed me to be involved	Information collected inaccurate
It help validate the abuse	
Process generally went well	

THINGS WHICH NEED TO BE CHANGED

Overall organization of the process needs to be improved.
Skill and sensitivity of interviewers needs to be improved.
Offender should be dealt with more effectively.
Moms need to be more involved and allowed to be supportive to their child.
More trained professional child therapists.
Do not treat all cases the same.
Need more advice, involvement, decision making for the victim/mom.
Could be better organized.
There needs to more support for victim\Moms.
Allow Moms to support their child.
The process needs to be speeded up.
There needs to be a support system for victims/Moms.
Process needs to be more sensitive to children.
There needs to be more skilled therapists.

B. Intervention

Some of the things that several of the Moms found very helpful during the intervention by CFS was that there was emotional support available. There was reassurance that it was not their fault. Several agencies did provide support including Child and Family Services, Anderson House, counsellors, and so on. One Mom stated, ***" Our worker was supportive and understanding of her needs . She didn't make me feel guilty."*** However, this support was variable and there were other respondents who identified unsupportive experiences, describing the whole experience as being negative through issues of lack of trust, workers' attitudes, lack of response, fairly to help them to protect themselves from an offender. Ten respondents suggested a number of helpful ideas such as:

a) giving the families more knowledge,
b) a buddy system to family,
c) issues of honesty among counsellors with clients,
d) support, advocacy and reassurance.

Several Moms recommended a number of changes, some directed towards the child and some for them. These included:

a) issues of therapy for the Moms right away,
b) advocacy,
c) individualizing each situation rather than stereotyping.

THEMES IN OPEN-ENDED RESPONSES-INTERVENTION

HELPFUL THINGS TO YOU	WHAT WAS UNHELPFUL TO YOU
They gave me reassurance	They were not sensitive
They gave me emotional support	System not responsive
They dealt with the offender	Everything not supportive

THINGS WHICH NEED TO CHANGE

There needs to be an advocate to assist victims and families.
More open, trustworthy and sensitive communication.
More immediate counselling and therapy.
More support and feedback to Moms
Make the system to respond quicker and more effectively.

C. Court Experience

Twelve respondents felt unhappy with the court experience. They were angry at the lightness of the sentence and the sense that it took too long for what the result was. One Mom stated,

> ***"We felt like we went through so much for nothing for two years."***

Another Mom stated

> ***"The sentence is completely unfair for what he has done. I'm living a life sentence."***

Another person stated

> ***"It takes so long to go to court. It drags on and we're afraid that when it eventually gets to court, it will get thrown out."***

Two respondents felt upset about the perpetrator being imprisoned. Twelve respondents were able to identify some helpful experience or person who assisted them through the process. Three persons reported the Crown was helpful for such things as explaining things and allowing the parent to be involved.

> ***"The Crown was extremely helpful. She explained things to me so I understood."***

Victim Services was helpful in 4 situations as well as a number of other agencies, friends, and so on. Sixteen respondents identified things that would have helped Moms cope better, including:

a) preparation;
b) information;
c) knowing what to expect;
d) a counsellor to assist them;
e) financial assistance;
f) the process being speeded up; and
g) better court procedures.

OPEN-ENDED RESPONSES-COURT

HELPFUL TO YOU	UNHELPFUL
The crown was sensitive to my requests There was support available from some. Knowing the procedures.	Sentence too light Upset at jailing perpetrat. Victim felt blamed

THINGS WHICH NEED TO BE CHANGED

Speed up the court process.
Better court preparation.
Longer-fairer sentences.
Change the court procedures.
Better preparation,explanation/information on the court process.
Should know what to expect.
A counsellor would help.

D. Therapy

Twenty respondents felt that therapy was helpful to the victim. Twelve respondents thought that there could be some improvements made. 4 identified issues related to assisting Moms in dealing with the child, from giving parents more facts about the situation, about abuse, and joint therapy sessions with Mom and daughter. One Mom stated

> ***"There needs to be more people able to respond to emergency situations."***

Sixteen mothers went for individual therapy and 4 attended family therapy.

OPEN-ENDED RESPONSES-THERAPY FOR MOMS

HELPFUL TO YOU	THINGS TO CHANGE
Help put things in perspective	More intensive support/therapy
Understanding and supportive	Support to the family
Offers explanations	More readily available resources
Affirm and normalize feelings	More specialized training
Provide information	More assessments
Help develop skills	
Reduce self-blame	
Express painful feelings	

Family therapy

Three of 4 respondents felt that the relationship between the therapist and family was good. Three of 4 felt that the therapist was helpful and 2 would refer someone else to the same therapists. One respondent felt that the therapist was not knowledgeable and competent, with another feeling that there a need for more time with the therapist.

Therapy - Perpetrator

Seven respondents had some concerns about provision of therapy to perpetrators with 2 respondents feeling that there was not enough family involvement or contact. Mothers generally felt that, for those who went to therapy, it was helpful but 16 had suggestions for some change. These included more intensive support and therapy for Moms, overall support for family, and more focus on family needs. In addition, there was a sense that there was a need for more services and available resources, with more specialized training. It was thought that there would be needed more assessments available and ongoing follow-up.

V.8 SUPPORT FROM FRIENDS AND COMMUNITY

Respondents reported that friends were very helpful, supporting them through the process. For example, during the investigative period, 83% saw them as very helpful. Through the overall process, 81% of respondents identified that friends helped a little or helped a lot, 72% viewed them as helping a lot.

The study was also interested in getting an understanding of how the community responded to the sexual abuse and the impact of this upon the family. Forty percent of respondents felt that the community did not view sexual abuse as a serious problem as compared to 100% of respondents who felt that it was. Ninety-two percent of the respondents reported that persons outside the nuclear family found out about the abuse. Eighteen respondents reported that close friends knew, reported that other relatives found out, 9 reported that school found out, and 3 or 4 that neighbors found out. Seventy percent felt that they were treated differently after the response and 88% of these felt that people were more supportive to them. The most supportive persons to them was close friends at 88%, followed by neighbors, relatives, school, with the overall community being rated at 64% supportive.

The respondents were able to identify a number of positive responses from others including:

a) that people were supportive and accepting of them;
b) that people offered help;
c) that external agencies were helpful; and
d) people offered encouragement.

It was also mentioned that the process helped to pull the family together both within and outside the family. As well, the respondents did identify some negative reactions from the community including a sense of stigmatization and blame from overt acts of hostility such as abusive calls harassment, and reactions from extended family members related to the offender, with several reporting no negative reactions.

V.9 OVERALL HELP:

The respondents were asked to rate on a scale from "helped a lot" to "made things worse" how the various agencies, family, friends, and so on assisted them in the whole process. Therapy was identified as the most helpful process for Moms with rating of 5% helpfulness, followed by friends, Victim Services, with the court experience having the lowest rating at 47%. The Moms identified a number of things that were helpful to them through the process, and particularly identified a number of agencies and individuals in the community who provided support to them from R.C.M.P. to Richmond Centre, Anderson House, and so on. The feeling and the assurance that the victim was getting help was the most helpful part for some as well as the fact that friends supported them. A couple or Moms identified some personal changes and awareness in themselves and a sense of personal closeness that developed between the victim and themselves, and the family as a whole.

As well, the respondents identified what was the most difficult part of the process for them, including:

a) the shock of what had happened;
b) the damage that the abuse had done to their child; and
c) some problems with the disclosure process.

Several persons identified the court process as being extremely hard, one stating that,

> ***"It was all hard. The hardest had to be court, standing outside the court room and hearing her cry hysterically and not being able to help her. The anger was hard."***

The respondents also talked about the time lapse with the delay. Several respondents had personal feelings of helplessness, powerlessness and just worry about what was going to happen. The experience of betrayal by the perpetrator was very difficult to deal with and the fact that there was a feeling that the offender was not being held accountable. Below are general headings of open-ended responses of Moms about their overall experience, including what was helpful, what was helpful, what was the hardest part of the whole experience and what needs to change.

OPEN-ENDED RESPONSES- OVERALL

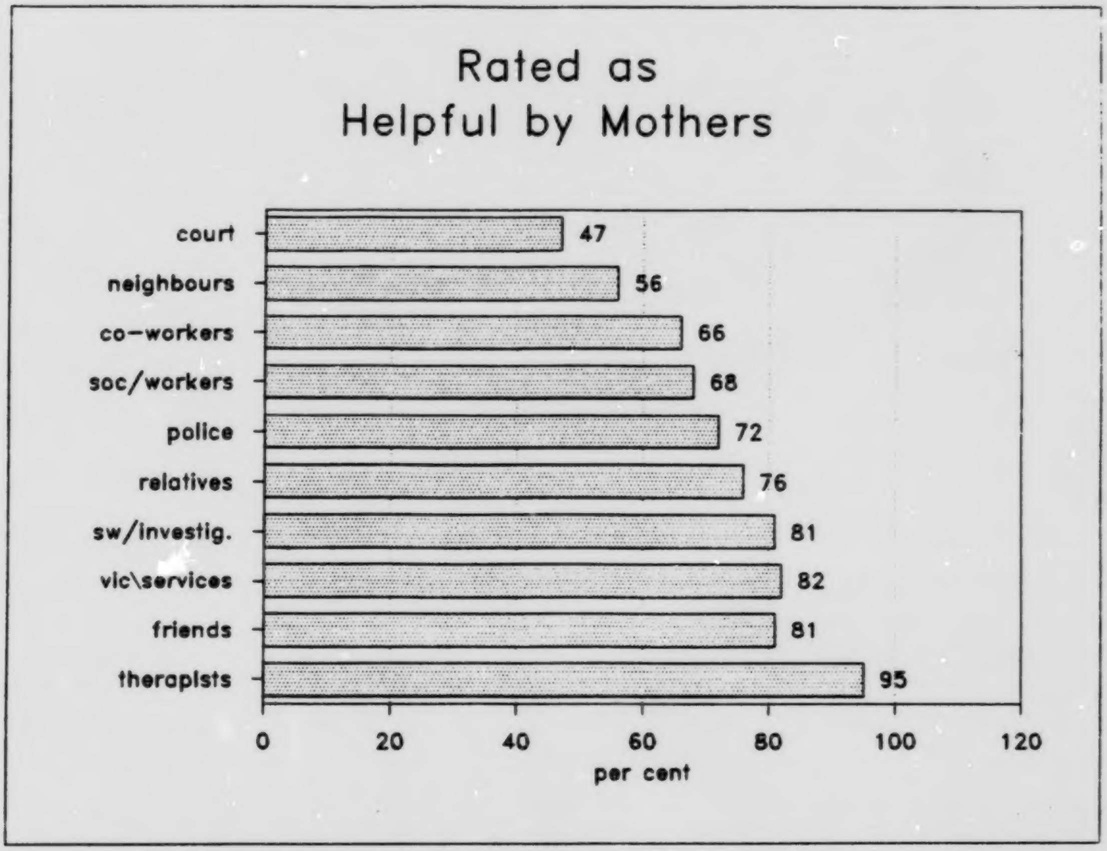
HELPFUL THINGS	UNHELPFUL AND DIFFICULT THINGS
Some agencies helped victim get help	Stigmatization and blame
Personal friends helped	Overt acts of hostility
Personal changes/awareness	Family reactions
Personal closeness to family	Shock of what happened
People were supportive and accepting	The damage the process caused.
People offered help	Feelings of helplessness, powerlessness and worry.
Workers in agencies were helpful.	Being betrayed by perpetrator
People offered encouragement	
Pulled family together	

WHAT NEEDS TO BE DONE TO HELP VICTIMS AND FAMILIES

Public education to break the silence
To understand the problem, and how to support victims and families better.
React more supportively and honestly to families and victims.
Families need counseling and support.

Table 2 displays the levels of helpfulness of friends, relatives and agencies to mothers.

TABLE 2:



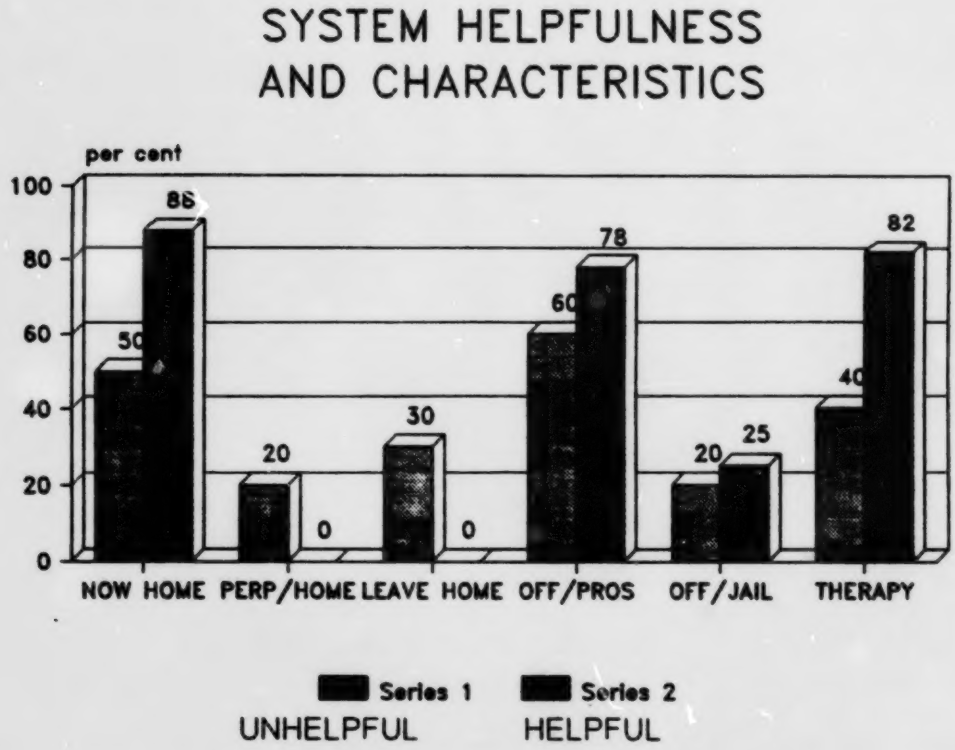
V.10 FURTHER ANALYSIS ABOUT THE CONCEPT OF SUPPORT

The study was interested in knowing not only what was supportive but also whether there were any characteristics or factors which may determine the ability of a family to have a supportive experience with the system. Each respondent's score was averaged for each contact with the system and community. The averages clustered around a mean of 2, with some minor variances showing a high score of 2.71 and a low of 1.00. Further analysis which focused on the level of helpfulness of agencies only, identified scores with wider variances of means. An analysis of cases which scored greater than 2 indicated a more positive experience with the system and scores under 2, indicated a less helpful experience with the system was undertaken.

There were 16 families who scored greater than 2 (helpful) and 10 families that scored under 2 (unhelpful) Of the 10 unhelpful experiences, 5 of the victims are currently living outside the home as compared to 2 of 16 in the helpful category. In the unhelpful category, in 2 of the 10 situations the perpetrator now lives in the home as compared to no perpetrators living in the home in the 16 helpful categories. In the unhelpful category, it was reported that 3 of the families had to leave the home at the time of disclosure.

In the families where helpfulness scores were higher, 78% of the offenders were prosecuted, with 25% of the offenders jailed while in 60% of the low helpfulness category the offender was prosecuted and 20% were jailed. Thirteen of the 16 victims went for therapy in the high score group while only 4 out of the other group went for therapy in the low satisfaction category.

TABLE 3:



V.11 INTRA-/EXTRA-FAMILIAL ABUSE

The study was interested in getting an understanding of those aspects which were important and specific to understanding intra- as compared to extra-familial abuse. The interview sample of 26 contained 19 intra-familial abuse and 7 extra-familial. The predisclosure marital status for intra-familial was 9 of the 19 were married while 6 of 7 were married in extrafamial cases 6 of the victims in the intra-familial abuse were now living outside the home as compared to 1 for extra. There were no marital problems reported for extra-familial abuse predisclosure but there were 2 out of 7 cases that identified family problems. For intra-familial, 8 of the 18 respondents reported marital problems, with 14 out of 18 reporting family problems. In extra-familial abuse, the major problems included child/parent and financial, while within intra-familial abuse, the major problems included child/parent, marital conflict, employment instability and drug/alcohol problems. Both intra- and extra-familial abuse families identified major traumas predisclosure, with intra- having 12 respondents identifying trauma and extra- 4 respondents. Both intra- and extra-familial cases identified good support outside the family with 7 of the extra cases identifying good support, and 14 of 18 in intra- identifying support. The level of support and contact with extended family was reported as higher among extra-familial cases with 57% of intra-familial reporting support from extended family and 44% reporting regular contact. Extra-familial reported 71% for both of these categories.

The relationship between dad and victim in terms of closeness varied as all respondents in the extra-familial cases identified close relationship whereas in intra-familial abuse about 50% reported close relationship with Dad and 12 out of 18 identified a conflictual relationship. Sibling support for intra-familial abuse was reported as lower.

Intra-familial abuse reported that 66% of the victims had emotional problems before the disclosure and that 71% of extra-familial victims also had emotional problems. Physical problems were more evident for victims of intra-familial abuse with intra reporting 61% and 16% for extra-. Behavioral problems were reported at the rate of 66% extra- and 57% intra-. Both intra- and extra- reported that the victim had disclosed previously with 16% of intra- having disclosed and 28% of extra-. Eight intra-familial respondents reported that there were signs which would have suggested abuse previously and 2 extra-familial abuse reported the same. In extra-familial abuse, the response of the mother and family was more clearly supportive of the victim whereas in intra-familial abuse, there were more conflicted responses even though the responses of the mother continued to be on the whole supportive.

The responses of the families to intervention varied for intra- and extra-familial abuse. In intra-familial abuse, the family perceived the intervention by Child and Family Services, for example, as friendly, trustworthy, and felt that workers were less experienced. For example, 33% of intra- felt the response of Child and Family Services was friendly while all respondents in extra-familial abuse felt friendly response. As well, all respondents in extra-familial abuse felt that they were involved in decision-making and informed about decisions, whereas in intra-familial abuse only 2 felt that they were involved in decision-making and 5 that they were informed about decisions.

Only 1 of the victims in the extra-familial abuse had to testify in court as compared to 6 of the intra-familial cases in which the victims had to testify. For intra-familial abuse, 11 of the 12 respondents were unhappy with the disposition of the court, with 3 respondents reporting being unhappy about the disposition for extra-familial.

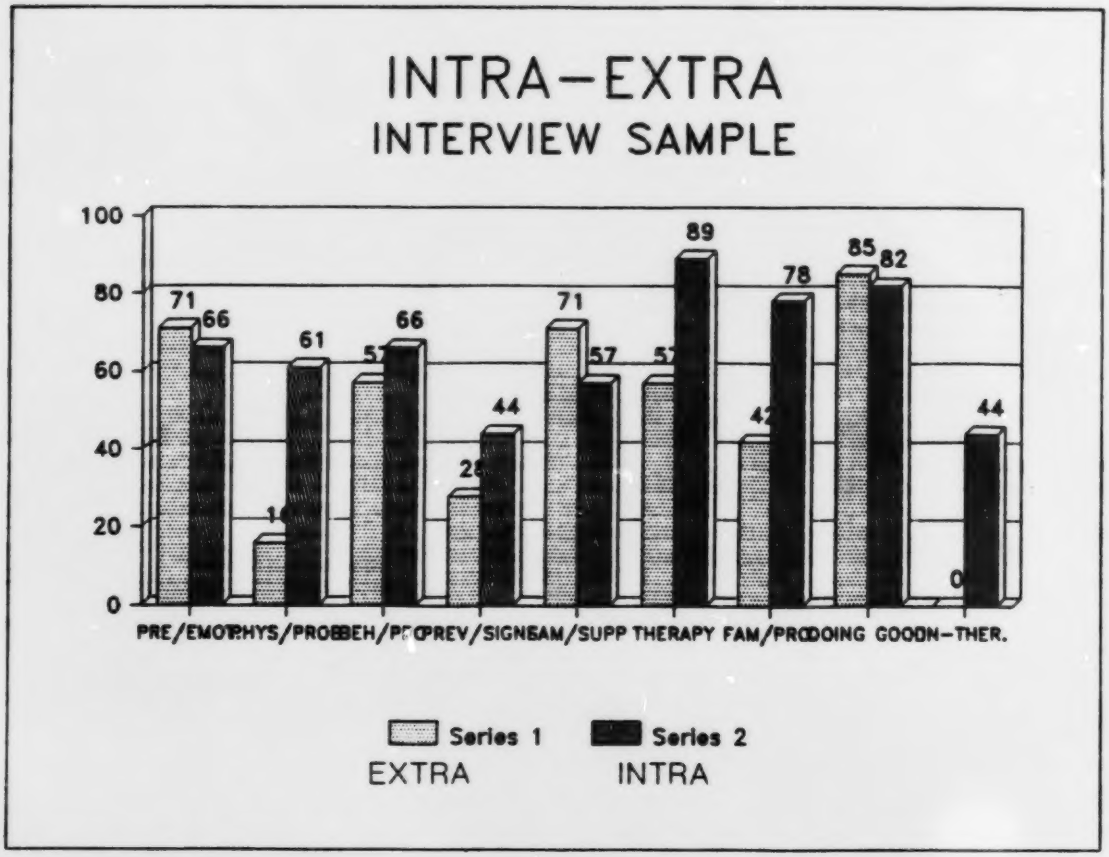
Twelve of the intra-familial respondents went for therapy and 2 extra-also went. Respondents for both intra- and extra-familial abuse reported a positive experience in therapy with 100% in each category stating that therapy was helpful. There were no extra-familial cases that attended family therapy, but 4 intra-familial cases attended.

Only 52% of intra-familial respondents felt that society considered the sexual abuse as a serious problem as compared to 6 out of 7 respondents in extra-familial abuse. All of the respondents themselves considered sexual abuse as a serious problem.

In terms of current family problems, 15 of the 19 (78%), of intra-familial abuse stated that there were still family problems with 7 of 16 respondents being in therapy and 8 victims still in therapy. Five of the intra-familial respondents felt that the problems were related to sexual abuse but others were unsure. Fourteen other respondents were identified as doing good or very good. For extra-familial abuse respondents, 42% reported that there were still family problems. Three respondents and the victims were currently in therapy and one respondent felt the problems were related to the sexual abuse, 2 others were unsure. Six of the 7 respondents felt that the victim was currently doing good or very good.

Comparing how much other persons and agencies helped intra- and extra-familial cases, there appeared to be very little overall variance. Seventy-four percent of extra-familial cases reported a supportive and helpful experience and 71% of intra-familial cases reporting the same. In examining the degree of helpfulness of the formal agency system, extra-familial abuse respondents identified 78% satisfaction. The helpfulness rating for intra-familial cases is 69%. Both intra- and extra-familial tended to rate the court experience as quite low at 41 and 42% helpful. Taking out the rating for the court, the ratings within intra-familial abuse tended to vary less than those for extra- ranging from 63 to 89 with most clustering between 63 and the low 70's. In extra-familial abuse, the scores range from 50 to 100.

TABLE 4:



V.12 FAMILY ASSESSMENT DEVICE

The General Functioning subscale (GF) of the McMaster Family Assessment Device (FAD) was administered to families and victims with a total of 29 completing the GF scale. Thirty-one scored 2.17 or over, which is determined as the cutoff point in identifying family dysfunction. The Ontario Health Survey identified 10% of families in this range in their survey.

V.13 KEY INFORMANTS-ADULT SURVIVORS

Twenty seven adult survivors were interviewed as part of the needs assessment. As regards families, adult survivors highlighted the need for the victim to receive a great deal of parental support and understanding as well as lots of love. It was highlighted that the family should "listen and believe."

V.14 INFORMATION FROM THERAPISTS ON CHILDREN IN THERAPY

Information on 36 children in therapy was completed by therapists. The information covered a number of areas, including supportive of parents to the victim as well as the relationship of parent to therapists. When asked to characterize the response of the mother and non- offending father to the victims' disclosure and general level of support at home from unsupportive (1), through rejecting, angry (4), to very clear support sensitive (7), the therapists rated their responses as follows;

	1 unsupportive	2	3	4	5	6	7 supportive
MOM							
disc	4	3	2	0	9	8	10
gen	3	3	3	1	9	6	11
DAD							
disc	1	1	3	0	5	1	2

Nine mothers (25%), and 5 fathers (40%) were identified as providing an unsupportive response to disclosure. As well 25% of Moms were seen as not having a consistent supportive relationship with the victim. The therapist was also asked to rate their relationship with the mother. Six of 33 identified the relationship as fair to poor with 1 being classified as poor.

V.15 FAMILY - CHILD AND FAMILY SERVICES INFORMATION

Information was collected on families as part of a data schedule filled out by Child and Family Service workers covering two time periods from 1986 to 1989 and from July 1990 to March 1991. The data schedule looked at such factors as family composition, background history, type of abuse, and family factors including family supports and services utilized.

A. Past Cases:

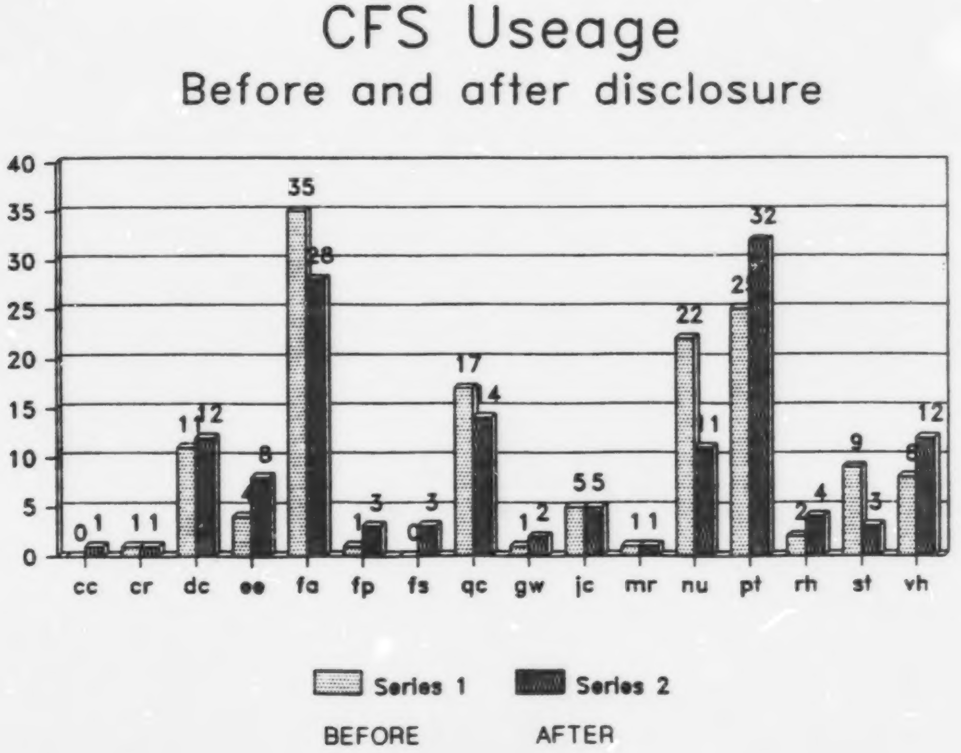
There were 79 validated cases of C.S.A. reviewed through case records of Child and Family Services. Fifty-five percent of the victims were from nuclear families and 24% step-families. Thirty-five percent of the families presented with previous marital conflict with 37% being identified as presenting with marital instability. Nineteen percent of these families presented with a previous history of spouse abuse, with 21% presenting with child abuse. Forty-four percent of the families were not currently employed, with 28% being on welfare assistance. Seventeen percent of Moms and 30% of Dads presented with alcohol problems. Forty-six percent of the victims and 65% of the families were identified as having presented with previous problems, the major problems being marital and emotional problems. Twelve of the victims were male and 67 female. Fifty-six (71%), of the cases were intra-familial, with 26 (33%), being parental abuse, with 23% being biological parent abuse. Initial disclosures were made to 32 direct-family members, with 16 of those being mothers, and 8 step-fathers. Sixty-five (82%), of the families responded in a supportive fashion to the disclosure by the victim.

After the disclosure and investigations, referrals of the family and victim were made to a number of agencies. Thirty-four families were referred to Community Mental Health Services, 4 to Catholic Family Services, 1 Protestant Family Services, 2 to private psychiatrists, 7 to Addictions. Thirty-eight family referrals were made in all. Seventeen families moved from the home, with 33 receiving extra services from Child and Family Services.

Ratings were made on the parents' social ties outside the family and 16 (22%), were estimated as low in contact outside the family. The families were also rated on a scale of cohesiveness, expressiveness, and conflict, 3 factors important for internal support within families. Twenty-seven families (35%), scored low on cohesiveness; 35% low on expressiveness, and 36% high in conflict.

A review was done of the services that these families received from Child and Family Services previous to disclosure for a total of 142 services offered to the families. The major service offered was financial assistance to 35 families, followed by protection to 25 families. Following the disclosure, the families utilized a total of 140 service units, the major being protection by 32 families and family assistance by 28. See table 5.

TABLE 5:



B. Cases Currently in the System:

A further review of cases in the system from July 1990 to March 1991 was done utilizing the same data schedule. There was a total of 90 cases reviewed, of which 43 cases (48%), were validated to date. Of the total of the 90 cases currently in the system, 35 demonstrated marital conflict and problems, 20 with a history of spouse abuse and 23 with a history of child abuse. Fifteen of the victims in 36 of the families had presented with problems previously. The major family problem was marital conflict, alcohol/drug problems, financial problems. The victims were 10 males and 80 females. The major types of abuse were:

a) fondling (53);
b) oral/genital contact (24);
c) anal/vaginal intercourse (17), of which 36 were identified as having violence or coercion.

Fifty-six percent were intra-familial abuse, with 28% having a parental offender of which 18% was the natural parent. Thirty-two families were referred for therapy. Thirty-nine percent of the families had low or poor social ties outside of their home system. In terms of family characteristics, 36% of families scored low on cohesiveness, 50% were low on expressiveness, and 36% scored high on conflict.

C. Children in the System:

A further analysis was done on 64 cases that had been in the system in 1990 for up to 4 to 6 weeks. This was completed by social workers on cases that were currently active on their case load. Thirty-three of these cases came from nuclear families, 15 from one-parent families and 8 from step-families. The project rated the reaction and level of support that the victim received from the person to whom they disclosed and it demonstrated 69 supportive reactions and 18 unsupportive. Five percent of the non-offending parents rated a level of supportiveness that was considered low. Thirteen percent rated the relationship between the victim and the mother or caregiver as poor and unsupportive and 25% of families showed a poor, unsupportive relationship between the victim and his/her father. When asked to characterize the mother's response to disclosure, it was estimated that 21% of the mothers showed an unsupportive response to disclosure, with 75% of Moms showing a supportive response. Workers estimated that 85% of the Moms were currently showing a supportive response to the victim with 89% of non-offending fathers being supportive as well. Twenty-five percent of siblings and other relatives living at home were currently showing unsupportive responses to the victim. The workers were asked to identify those who were in contact with the victim, and whether or not they were providing a support. Eighty-two percent of mothers were identified as providing support, as with a 88% of Child and Family Service workers, 80% of fathers, and 78% of therapists.

It was felt that after disclosure 77% of all the families needed emotional support,with an estimate that 73% received the level of support they needed. It was felt that the family had a number of general needs including counselling (42), income (12), child care (11), housing (7), and other needs (7). The main support system before and after disclosure was the immediate family, for 60% of cases, with 53% identifying friend(s), and 51% other relatives.

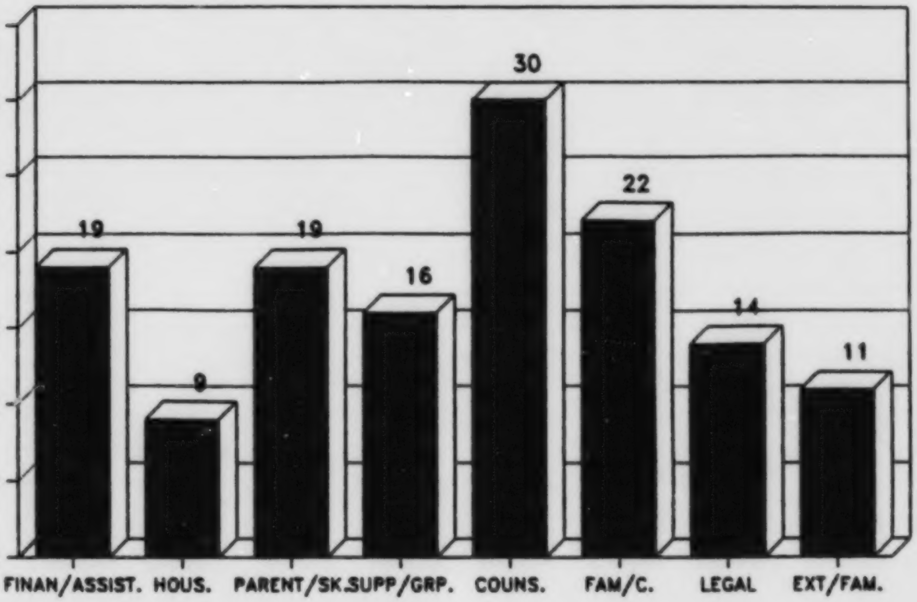
Sixty-six percent of mothers were identified as being able to recognize the problems the child had at present and were aware of their needs. In terms of being able to protect the child from further abuse, workers estimated that 29% had a very minimum ability to protect, with 6% having some limited ability. Twenty-three percent of the parents were identified as somewhat to highly resistive in cooperating with the Department.

Twelve families (19%) were identified as having a high need for financial assistance, 6 (9%) for housing, 12 (19%) for parenting skills, 10 (16%) for support groups, 19 (30%) for individual counselling, 14 (22%) for family therapy, 9 (14%) for

legal services, and 7 (11%) for extended family support.
When asked to characterize their relationships with the mother, 14% of the cases were identified as having a poor relationship with the worker, with 15% felt that the mother/caregiver had a poor level of trust in the worker at this time. In terms of rating the level of seriousness of the case, 54% of the cases were identified as moderately or extremely serious, with 6 cases (15%), as extremely serious.

TABLE 6:

FAMILY NEEDS



V.16 FAMILY HEALTH SCALE RATING

Child and Family Service Workers were asked to rate 64 families of child sexual abuse victims currently in the system on 9 dimensions of family functioning, selected from the Family Health Scale (FHS), developed by The Families Studies Group, Department of Psychological Medicine, The Hospital for Sick Children, London, England. The full instrument measures overall family functioning. For this needs assessment, only a few dimensions were selected for rating and it is not meant to be considered as measuring total family functioning, but only to give a perception of workers on possible areas of functional concern among a sample of families.

The structure of the FHS is based on 6 major dimension of family functioning including affective expression, communication, boundaries, alliances, adaptability and stability, and family competence. The sub dimension that were rated in this assessment were (aff/express.) emotional involvement, (boundaries) family relation to the environment, cohesion, (alliances) marital relationship, parental relationship, parent-child relationship, and sibling relationships, (adap/stab.) family stability, adaptability of family organization and (family competence) decision making.

The rating scale is from 1 to 7, with 1 indicating breakdown of functioning, a score of 3 indicating clear dysfunction, 5 indicates adequate functioning, and 7 indicates optimal functioning. One advantage of the scale is that there are generally clear descriptors for the various levels which is very useful in a general survey. The results must be considered with caution, as there was no formal training available for the raters and no test of rater reliability. There were some further ratings through the data schedule examining cohesiveness, expressiveness and conflict with the some of the same cases and the findings of problems in these areas was consistent across cases.

In comparing the 49 cases rated across all 9 dimensions, 15 (31%), scored under an average of 4. The scores in this group varied from 1.6 to 3.9. Seven (14%), scored under 3. In reviewing each sub-scale, family stability had the highest percentage rating under 4, followed by decision making, marital relationship, and relationship to environment. The highest percentage rating 3 and under included marital and family stability at 43%, followed by family organization at 39%, and emotional involvement at 37%. In calculating the mean score in each dimension, the scores ranged from a low of 3.32 for marital to a high of 4.82 for sibling relationships. In looking across those dimensions which are part of major family functional scales, family bond had 45% of ratings under 4, and 34% under 3, with a mean rating of 3.87. Family alliances had 43% of ratings under 4 and 41% under 3, with a mean of 4.15. Family stability had 53% of the ratings under 4 and 41% 3 or under with a mean of 3.97.

TABLE 7:

Ratings of Family Functioning

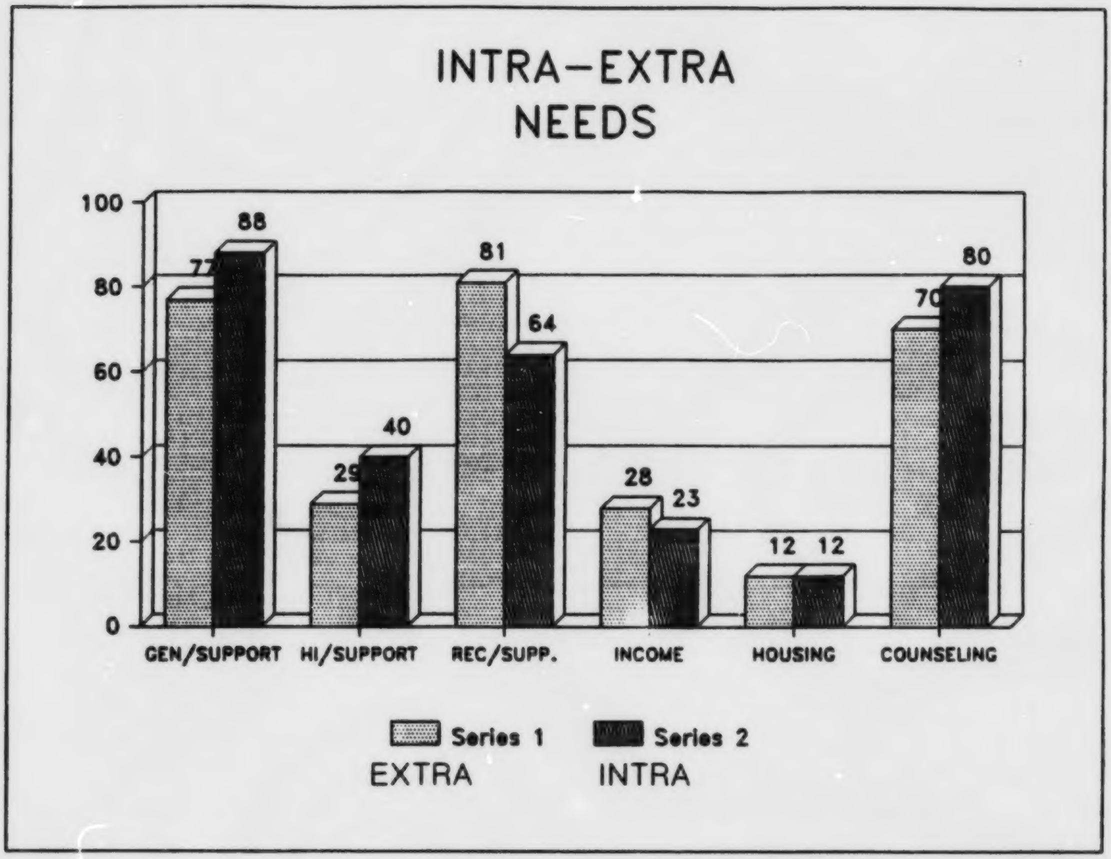
Dimensions	Number	< 4	< 3.1	Mean	Mean
Bond					3.87
-Rel. to environment	51	24/47%	17/33%	3.82	
-Cohesion	52	23/44%	18/34%	3.80	
Stability					3.97
-Family	47	27/57%	20/43%	3.78	
-Organization	48	23/48%	19/39%	3.14	
Affective					4.00
-Emot/Involv	51	20/39%	19/37%	4.00	
Alliances					4.15
-Marital	47	14/51%	20/43%	3.32	
-Parent/child	51	21/42%	11/22%	4.43	
-Sibling	38	14/36%	8/21%	4.82	
Competence					4.30
-Decision making	47	25/55%	16/31%	4.30	

V.17 INTRA-/EXTRA-FAMILIAL ABUSE - CURRENT CASES IN CHILD AND FAMILY SERVICES

Analysis was done on 61 of the 64 cases currently in Child and Family Services examining profiles of intra- and extra-familial cases. It must be noted that these are complaints only and all of them have not been validated as yet. There were 25 extra-familial and 36 intra-familial cases. For intra-familial, 50% were from nuclear families, 25% from one-parent, 17% from step-families. For extra-familial, 60% were from nuclear families, 32% one-parent families, 8% step-families. Thirty-two percent of extra-familial cases had previous contact with Child and Family Services as compared to 28% of intra-familial. The supportiveness to the victim in extra-familial cases was slightly higher than intra-familial, with 38 supportive responses to disclosure for 25 cases and 39 positive responses to disclosure from 36 cases. In examining the current supportiveness to the victim, 36% of intra-familial cases demonstrated a non-supportive relationship between the family and the victim compared to 18% of extra-familial cases. Marital problems were present in 19% of extra-familial cases and 48% of intra-familial, with 71% of mothers having close relationship with victim in intra-familial cases and 86% extra-familial cases. Sources of support to intra-familial cases were slightly lower than extra- with an average of 3.6 supports for intra- and 4.8 for extra-.

According to Child and Family Service workers, it was felt that 77% of extra-familial cases required a medium to high level of support with 29% requiring a high level of support compared to 88% of intra-familial requiring medium to high support with 40% requiring a high level of support. In the opinion of workers, 81% of extra-familial families received the required level of support as compared to 64% of intra-familial families.

TABLE 8:



The types of services required do not vary between intra- and extra- with both requiring 11-12% housing, 20% income, with extra- demonstrating a higher need for child care at 32%, with both requiring counselling services at the rate of 65-66%. The sources of support to intra-familial abuse seemed to be less available at the average of 1.8 per family compared to 2.24 per family for extra-familial abuse.

Workers were asked to rate on a scale of "minimum support" to "high support" needs a number of categories for families. These included financial, housing, parenting support group, individual therapy, family therapy, legal services, and extended support. Below is a table identifying the percentage of cases requiring from medium to high support in both extra- and intra-familial abuse.

Workers were asked to rate how disturbed the child was by the sexual abuse experience and 66% of extra- and 62% of intra- identified the victim as somewhat or extremely disturbed by the experience. Fourteen percent of extra- and 19 percent of intra- were identified as extremely disturbed. In terms of overall adjustment, 74% of intra- and 90% of extra- were identified as doing fair or very good.

When asked to rate sexual abuse on a continuum of "least serious" to "extremely serious", 42% of extra- and 64% of intra- identified the cases from moderate to extremely serious, with 19% of extra- and 28% of intra- identifying the cases as more serious.

In reviewing levels of functioning over the 9 dimensions of the Family Health Scale, intra-familial cases had lower scores and functioning as compared to extra-familial cases over all dimensions. Intra-familial abuse identified 112 responses over the 9 dimensions which were 3 or under, indicating a poor level of functioning as compared to 32 responses among extra-familial cases.

V.18 INTERVIEWS - THERAPISTS

Interviews were held with 8 therapists who are providing therapy to child sexual abuse victims and their families. The area of family treatment was seen as a major problem from several perspectives including availability, accessibility, quality and general philosophy of treatment. There appeared to be limited work in this area and very few therapists would identify themselves as having specialized skills in this area. As well, there seemed to be little therapy being provided to whole families, especially in intrafamilial abuse involving the perpetrator. Some therapists have an absence of faith in the concept of successful family reunification, claiming that it sounds like a nice idea, however they have not seen it happen in their practice.

There seemed to be more work with Moms of victims of sexual abuse. The difficult role for mothers was highlighted by therapists. They are asked to make what for many people would be an impossible decision. They are often expected to make decision between people they love, are dependent upon, both financially and emotionally, possibly fearful, and making this decision instantly and not showing ambivalence or any sense of wavering. The expectation of Moms to protect their child under all circumstances, irrespective of conditions, may place unrealistic expectations on them. There appears to be a need for a more understanding attitude towards the ambivalence and the process that Moms may need to go through to deal with the dilemma and ambivalence of the situation.

Respondents generally felt that there was a need for more supportive and therapy services for Moms. There was an emphasis that Moms not only needed help in addressing the needs of their children but also needed assistance for themselves that H was focused on their needs. It was felt that strong emphasis had to be placed on mobilizing the resources of Moms to feel confident in their roles with the victims. Some of it involves working with the mother and daughter jointly. One therapist stated "They (Moms) need help and support, because they live with them 24 hours of the day. If we think we are going to do it all, it is b.s.." Therapists saw work with siblings as a needed but a neglected area.

V.19 FAMILY NEEDS - LITERATURE

The literature on services to families of sexual abuse victims identifies a number of important needs that must be addressed in order to provide effective healing. The ability of the family, and often the mother in intra-familial abuse, to provide the required level of parenting to the child is an important protective factor in the future adjustment of the child. It must be recognized that the crisis of disclosure of child sexual abuse places a major stressor on the family and that there is a need for supportive, empowering resources to assist the family through this time and future intervention of the system. At the same time, the abilities of parents to provide the support is a factor of their own history, social support system, specific belief systems, financial resources, ability to solve problems, physical health and energy, good morale, and the absence of psychiatric disorders.

In the provision of services to families, it must be recognized that some parents of sexually abused children present with considerable problems and difficulties in their own histories. The ability of parents to provide the necessary support and safety to the child can sometimes be affected by their own history of victimization. In a study by Egeland et al (1988) of at-risk mothers with a history of physical abuse during their childhood but who did not repeat this with their own children, the abused mothers who are able to break the abusive cycle are significantly more likely to have participated in therapy at some time during their life and to have a more stable supportive, satisfying and non-abusive relationship with a mate. Abused mothers who reenacted their maltreatment were more distressed, anxious, dependent, immature and depressed. It is suggested that one would expect that parents who have some of the resources necessary would also be able to enlist and follow through with support from helping services. As a result, some families may require considerable intervention services from support to intensive therapy in order to impact on the cycle of abuse.

Jones (1987) who wrote Child Abuse and Neglect, identified a number of variables that would identify families as high on the list of difficult-to-treat families. These include lack of acknowledgement of abuse, known history of mother having experienced incest, use of force or sadism, lack of mother-daughter closeness, abuse not reactive to family stress, and so on. As such, in order to have an impact on a certain percentage of families, it will be necessary for the system to create a context of involvement and intense support as well as availability of ongoing supportive psychotherapy both for mother and family as required. In order for treatment to be effective, it is important for therapists to understand family dynamics and also the role of sexual variables which may impact on the presence of sexual abuse. According to Friedrich (1990), psychotherapy of sexually abused children and their family has a number of working assumptions that should be considered in providing psychotherapy services to incestuous families and sometimes also to non-incestuous families including:

(1) The therapist must be active and willing to direct therapy;

(2) The welfare and safety of the victim and siblings are paramount;

(3) Believe the victim and do not engage the offender in his denials;

(4) Preferably remove the offender and not the victim from the home;

(5) The appropriate authorities have been notified;

(6) Therapist has assumed therapy case management responsibilities and is coordinating treatment responses with Social Services;

(7) Information can be exchanged with Social Services and the legal system;

(8) It may be that unification is not possible and that decision must be an option;

(9) Within the above parameters, the therapist is willing to work with all persons involved.

Some of the issues that must be dealt with include the establishment of therapeutic relationships, involvement of various family members, empowerment of mother, and dealing with child/ parent conflicts. In dealing with the perpetrator as part of the family context, the importance of responsibility and creating a personal sense of safety within families must be addressed.

Gelines (1988) suggests four criteria to be used to measure successful treatment outcome, including:

(1) The definite termination of incestuous abuse;

(2) A healthier family structure with greater individual autonomy in all members;

(3) Enhanced communication;

(4) Improved conflict resolution skills.

Additional criteria:

(1) Significant improvement in the marital relationship where appropriate;

(2) A decrease in the victim's level of parentification and an increase in self-esteem and assertiveness.

Other authors identify success criteria as correction of the mother/daughter relationship with the mother feeling able to protect herself and the daughter believing that she can use her mother for protection. One of the issues identified in the literature is that sometimes these families are terminated too early and need more ongoing support or therapeutic intervention and monitoring.

As such, the role and function of the therapist in providing services in the area of sexual abuse must be one of an active involvement with some issues of monitoring, accountability, and ensuring safety.

The role of individual Moms and family therapy was highlighted in providing required services to families. The orientation of these services must be addressed and some consensus of focus and goals. For example, through the literature and in practice there seems to be a polarization of philosophies concerning the concept of the goals of family therapy. One extreme is the issue of integration of the family at all costs, including the perpetrator, and at the other is the removal of the perpetrator from the family as the final goal of intervention. It would appear that both extremes are dangerous and, more aptly put, probably naive. There is a need to work with the reality of the abuse situation with the firm goal of assuring protection, safety, and ongoing growth of the victim. Focus needs to be on the empowerment of the victim and non-offending members of the family, with a very free focus of accountability for offenders for actions with the realization that the goal of family unification may be an acceptable one but one which needs to have an accountability system which assures that there be no further revictimization.

V.20 DISCUSSION

In examining the needs of families as they relate to victims, there are a number of key areas which have been identified. In particular, the issue of support between family and victim is of paramount importance in providing a healing experience to asssure recovery. As well, the type of support that the family receives will in effect often be one of the major factors in the ability of that family to provide the nurturing, caring and supportive experience to the child. The ability of the family to provide this support will also be a factor of the kinds of strengths and problems that that family may have experienced previous to the disclosure of the abuse. This study has looked at all of these areas and has identified a number of needs which must be addressed in order to provide an effective service to children who have been sexually abused.

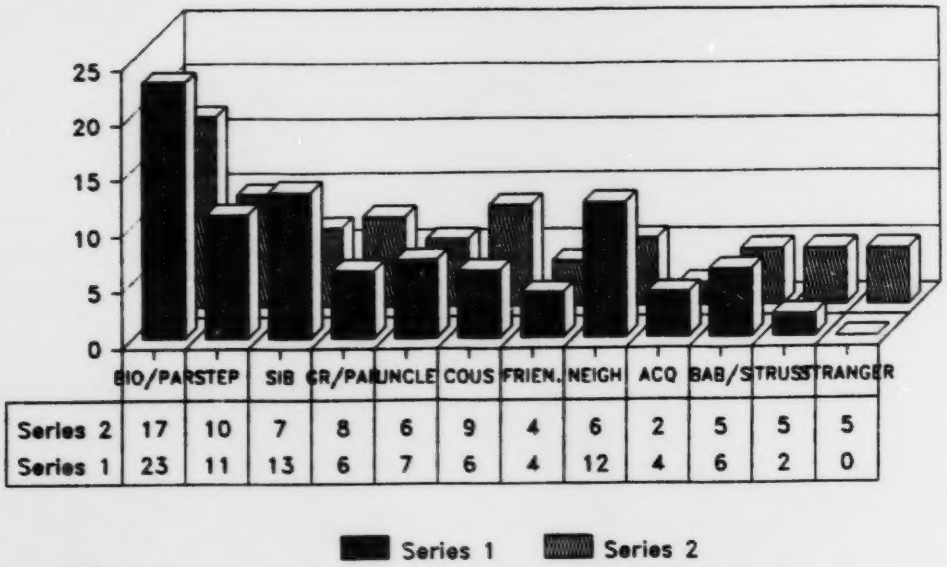
A. Support Between Family and Child:

The study looked at the nature of the relationship between the family and the child, including issues of supportiveness, closeness, conflict, and so on. This relationship was reviewed from a number of perspectives: from that of the victim, from the families themselves, from therapists, as well as other data sources through Child and Family Services.

When we talk about the supportiveness of the family, in some circumstances we are talking about mothers, in others mothers and fathers, siblings, as well as extended family. Within our family interview of 26, 19 (73%), were intra-familial abuse with 38% parental abuse, 27% of which were biological parents. Approximately 54% of those were single parent families. In a survey of past and present cases within Child and Family Services, for present cases 56% were intra-familial abuse, with 28% parental and 18% natural. Past cases had 71% intra-familial abuse, with 33% being parent abuse and 23% being biological parent. As such, when we are talking about supportive experiences by parents, approximately a third to a half may in fact be supportive experiences by mothers. The findings of the survey would appear to demonstrate that generally mothers (and sometimes fathers), have provided a supportive experience to the child upon disclosure which has continued throughout the process of intervention. In interviews with Moms among the sample of 26, the perception was of a close, supportive relationship to the victim with Moms being identified as the main source of support throughout the process.

TABLE 9:

Relationship to the Perpetrator



	BIO/PAR	STEP	SIB	GR/PA	UNCLE	COUS	FRIEN.	NEIGH	ACQ	BAB/S	TRUS	STRANGER
Series 2	17	10	7	8	6	9	4	6	2	5	5	5
Series 1	23	11	13	6	7	6	4	12	4	6	2	0

TABLE 4 % PAST % PRESENT

Moms were consistently identified as the most important source of support to the victim throughout the data collected by Child and Family Services; however, in reviewing responses of supportiveness by Moms, closeness to Moms and issues of family functioning, it appears that a range from 13 to 35% of families were identified as having somewhat to very unsupportive relationships to the victim. As such, it needs to be recognized that the ability or the opportunity of mothers and/or families to support the victim through the process of disclosure through intervention and so on, may require some ongoing assistance and support by the system. The experience of support by the victim is most directly affected by the supportiveness reaction of the mother and/or father but it is also influenced by reaction of siblings, extended family and so on.

It is recognized that intra-familial abuse, that which happens within the nuclear family, especially by a biological parent, step-parent or sibling, becomes the most complicated environment for providing a supportive relationship. Friedrich (1990) writes, "I believe that parental, particularly maternal responses, are much more complex and diverse, ranging from supportive to unsupportive and varying from the non-abusing parent knowing to not knowing about the abuse. Clearly, parental support is critical, outstripping abuse characteristics, in predicting at least short-term behavioral reaction to the abuse [Conte and Schuerman, 1987]. We gain far more leverage as therapists if we also realize the dilemma of women in our culture." The ability of mothers to provide clear messages of support to their child may be restricted by the diverse nature and complications of the sexual abuse experience itself.

Even though the sample of 26 families interviewed may not be representative of the total population of families of sexual abuse victims, it is clear that all the mothers had a strong sense of protectiveness and supportiveness towards their child and, in those few situations where support was not so clearly demonstrated that it appeared that mothers continued to provide some degree of support to assure protection of the child, often through indirect rather than direct means. As such, it is important, when developing any intervention system, that service providers recognize the dilemma that mothers face in often having to make choices between husbands, boyfriends, security, fear of reprisal and so on. At the same time, it is quite clear from the literature and from our survey, the role and function of parents, and mothers in particular, is extremely important in the healing process of the child.

Irrespective of whether the abuse is intra- or extra-familial, support to the victim from family, and often mother, appears to be a generic need of all victims. In relation to child sexual abuse, support should be operationalized by a feeling of being believed, a feeling of being reassured, protected, not feeling responsible for the abuse, being cared about, and having someone to talk to and share feelings with. As such, the system must recognize the need not only to mobilize parents but also to provide them with the assistance to provide this supportive response at the point of disclosure.

C. Sibling Support:

The role of siblings in providing a supportive experience to the victim appears to be important not only for the victim's recovery but also for their own understanding and ability to deal with changes that may affect them. Siblings throughout the study demonstrated generally supportive responses to the victim; however, there was also a considerable number, (7 of 17) who demonstrated non-supportive responses at the time of the investigation. It appeared from the key informant interviews and from other data that the siblings were sometimes in difficult positions, feeling caught in a situation of divided loyalties, fearful of what would happen to the family, and so on. It appears that the needs of the siblings to understand what has happened and to receive assistance is also very important in providing support services.

D. Other Relatives:

The survey demonstrated that relatives outside the family are important in providing support to the victim and family. The largest problem appeared to be in those situations where extended family were directly related to the perpetrator, i.e. father, mother/father, brother, and that this often created a major problem of not only hostilities from the extended family but also withdrawal of support from grandparents, uncles, and so on.

E. System's Support to Families:

In order for families to be able to assist the victim with not only the trauma of the sexual abuse but also to deal with the aftermath of disclosure, investigation, court, and so on, there is a need for a number of responses which include not only a sensitive, involved interaction but also certain resources available including financial, housing, as well as therapeutic resources.

In reviewing the data from the key informant interviews, it appeared as if respondents generally found the system helpful to them, with 95% identifying therapists as helpful, 82% Victim Services, 78% social work investigators, 72% police, 68% social workers, 66% co-workers, with a low of 47% court. It should be recognized that some interventions are more apt to cause distress than others, such as court compared with therapy. At the same time, some respondents found the experience of the system as being very unhelpful and, even among those who generally felt the system was helpful, there were many suggestions for changes and improvements. Recognizing differences in perception of individuals and taking this into consideration, it does appear that one of the difficulties in the system is that the response that one might receive on entering the system is a variable response and is probably more a factor of individuals within the system rather than a system that is developed in order to assure a high quality intervention.

Some of the key areas identified that need to be addressed include:

(1) Involvement of parents in the process;
(2) Information-sharing with parents;
(3) Decision-making for parents;
(4) A more organized, coherent and consistent process;
(5) Improved training and expertise at all levels;
(6) A more sensitized, child-focused service delivery;
(7) Availability of specialized therapeutic resources.

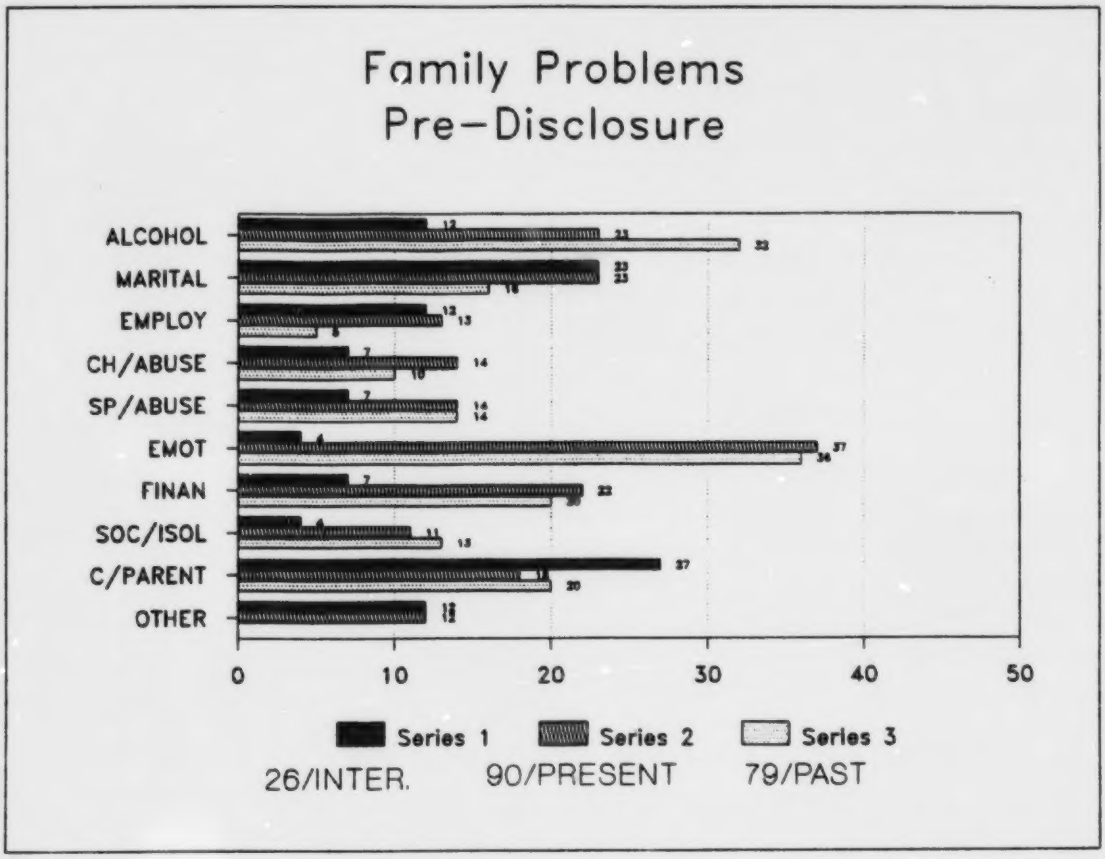
The data would indicate that families are utilizing a variety of services including financial, child care. In reviewing 178 cases, it was reported that families used 209 services after disclosure and victims 282 services. Fifty-three families (35%), were referred for family therapy. In a review of 64 cases currently in the system, families were identified as having a broad range of needs from housing to counselling, with counselling being identified as the major need in 42 (66%), of the cases. Twenty-one percent of families were seen as having a high need for family therapy, 68% were seen as having a medium to high. Thirty percent have a high need for individual therapy and 50% from medium to high. Other areas of need included parenting skills at 38% medium to high, support group 36% medium to high, financial 22% medium to high, and 13% housing. Seventy-two percent were identified as needing medium to high level of support with 72% of those estimated as having obtained the level of support needed. As such, it would appear that there is a need for a number of resources available to families including financial, housing, emotional support,information as well as individual and family therapy.

E. Family Resources/Problems:

The study also looked at factors which may identify a need for intervention in terms of supporting families. One of the issues in regards to the family's ability to provide resources to the child is related to the kinds of problems and difficulties that the family may have experienced previous to the disclosure process. Sixty-two percent of families of the key informants identified family problems previous to disclosure, with 43% of current cases reporting family problems, with 40% of past cases reporting marital problems. Twelve percent of the key informants identified alcohol problems, 23% marital, 27% child/parent. Similar problems were reported in relation to Child and Family Services information.

Table 10 identifies pre-disclosure problems with series 1 representing the 26 key informant interviews, series 2, 90 present cases and series 3, 79 past cases.

TABLE 10:



F. Family Assessment Device:

In reviewing the information from the MacMaster General Functional Scale for the key informants interviews, 28% identified as having some family difficulty, with 14% indicating clear dysfunction. It would appear that anywhere from 15 to 25% of families could have special needs which may range from financial to some type of family therapy intervention.

As well, the Family Health Scale has identified a number of dimensions of family functioning indicating that of 49 cases rated 15 of 31 scored at a level indicating some family dysfunction with 14% identifying a high level of dysfunction. It would appear that certain populations will require more intensive intervention at the level of support/involvement as well as therapy. It is important to be able to identify those risk factors which will involve a more intensive involvement in order to assure the safety, support and health of the child.

G. Intra-/Extra-Familial Abuse:

One of the objectives of the study was to understand the needs of families and the unique needs that intra- and extra-familial abuse families may present. It appears that there are some generic needs which are universal to both intra- and extra-familial abuse situations. The need for involvement, support, sensitivity, information appears to cut across both groups. At the same time, the study did identify that intra-familial abuse families will most likely require a more intensive involvement and access to resources. Issues of supportiveness to victim, level of family problems in most cases were clearly delineated from the data. At the same time, in order for our system to be effective, it must find ways to be able to respond to the needs of both types of families in order to provide healing for the victim. There must be a differential response based on need, and on the principles and philosophy of supporting parent or parents to assure an ongoing support system for the child. In relation to extra-familial abuse, this may be a factor of involvement, information, and assistance working through the parents or providing direct service to the parents where needed. In intra-familial abuse, the same procedure may be utilized, however, there needs to be identified a process for a vigorous support to families where the perpetrator is from within the family in order to assist all members through the process and, whenever possible, to keep the family integrated.

The provision of intervention into families of high need must utilize a number of support and therapeutic options. The role and function of support and therapy services must be defined within the realities of needs, rural context and resources. Identifying needs, with risk factors, with potential impacts under a principle of least intrusive intervention is required to assure efficient and effective intervention.

The role and function of individual therapy to Moms and families must be addressed in a model of intervention including issues of philosophy of intervention, role and function with other aspects of support information and crisis intervention.

V.21 SUMMARY-FAMILY NEEDS

The system of response must address a wide variety of family needs. Listed below are a number of needs, 20 in total which must be considered in providing services to families of child sexual abuse victims. These include a number of facilitative needs which must be generic to any helping service, but most especially are necessary in servicing victims and families. These include concepts like respect to families, caring, involvement and so on. Secondly the need to access services which are available , accessible, continuous and accountable is identified as extremely important in the assurance of a healing experience for victim and family. Other more specific services needs have been identified including need for financial assistance, child care, parenting skills treatment and so on. Level of need has been estimated based on the needs assessment and literature identifying some levels at 100%, for example the response of the system in terms of sensitivity, caring, and so on. Other needs will vary according to level of need of the population such as housing, therapy and so on. Those areas where there appears to be definable gaps have been identified and identification of factors which directly impact on the needs. For example, sensitivity is partially a factor of attitude, which is a factor of beliefs,feelings and behaviors. As well sensitivity is a factor of skills on demonstrating and providing sensitivity in sometimes difficult situations. Also, it is a factor of resources available to workers to have time and supports to allow sensitive intervention. And lastly, how services are organized will determine the ability of workers to provide the response necessary. Factors of needs should offer some directionality in the strategies to meeting needs.

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NEEDS FAMILY

NEEDS	LEVEL/NEED	GAP	FACTOR OF-	BELIEF	FEELINGS	BEHAVIOR	SKILLS	RESOURCES	ORGANIZATION
SENSITIVITY	100%	GAP		*	*	*	*	*	*
RESPECT	100%	**		*	*	*	*	*	*
CARING	100%	**		*	*	*	*	*	*
INVOLVEMENT	100%	**		*	*	*	*	*	*
SAFETY	100%	**		*	*	*	*	*	*
SELF DETERMINATION	100%	**		*	*	*	*	*	*
SERVICE ACCESSIBILITY	100%	**						*	*
SERVICE AVAILABILITY	100%	**						*	*
SERVICE CONTINUITY	100%	**						*	*
SERVICE ACCOUNTABILITY	100%	**	*	*	*	*		*	*
SERVICES HOUSING	10%	**							*
INCOME	20-25%								*
CHILD CARE	10-15%								*
HOMEMAKER	15%								*
EMOTIONAL SUPP	100%	**		*	*	*	*	*	*
FAMILY THERAPY	35%	**					*	*	*
SHORT TERM THERAPY	65%	**					*	*	*
L/T INDIV. THERAPY	30%	**					*	*	*
PROTECTION	30-40%	**					*	*	*

* indicates factor affecting need

VI. NEEDS AREAS - OFFENDERS

Since the study is mainly concerned with the assessment of needs directed towards providing supportive and empowering responses to the victim, we have committed only minimum resources to the study of offenders. Therefore, our aim in this assessment is to learn enough about offenders, their needs in the legal and therapeutic response to them to:

(a) identify directions for more intensive work;
(b) identify directions for treatment; and
(c) identify how legal and therapeutic interventions with offenders affect victims.

As Rogers (1988) suggested, "child sexual abuse is a criminal offense ... offenders must be charged [and] held accountable. This act alone is not enough, [there] must also be rehabilitation ... so that offenses are not repeated" (p. 9). In a brief submitted by the Canadian Psychological Association to the Working Group on the Management and Treatment of Sex Offenders established by the Solicitor General of Canada in 1988, it is stated that "policies concerning the treatment of sex offenders are necessarily complex; they must relate simultaneously to sentencing, probation and parole policies, the civil liberties of offenders, community safety, the rights of victims, and the issue of treatment efficacy. Programs of treatment for sex offenders must therefore be developed in the context of a variety of policies dealing with offender disposition. In addition, sex offenders are often involved with mental health and social service agencies before, after, or instead of their involvement with the criminal justice system. Clearly, therefore, policies pertaining to treatment must be coordinated across a variety of agencies and government jurisdictions."

A comprehensive program which provides services to victims of child sexual abuse and their families must address the issue of legal and therapeutic response to those who commit sexual offenses against children in Prince Edward Island. This population of sex offenders was viewed ten years ago as a small but deviant group of mentally ill people is now recognized as a much larger population, the majority of which would not be diagnosed as mentally ill. The number of sex offenders in federal penitentiaries serving sentence for sex offenses increased in recent years to the point where they constituted 11% of the incarcerated population in 1985. The Bulger Report found that, on Prince Edward Island over a thirty four month period, a total of 116 child sexual abuse offenders were identified. In recent years, the Community Mental Health Program has experienced a major increase in referrals for treatment of sex offenses. In 1985 there were only 2 cases referred for treatment. In 1986 through September of 1989, 84 cases were referred, of which 29 were adolescent offenders.

The objectives of this aspect of the study were:

(a) to develop directions for intervention with sex offenders; and
(b) to learn how intervention with offenders affects victims' experience.

The present study has attempted to identify numbers of offenders of offenders, type of offenses and offenders, nature of services available, and program options.

VI.1 METHOD

A number of methods were utilized to collect data concerning needs in the area of sex offender intervention:

1. Justice personnel filled out a questionnaire on 44 convicted sex offenders. The questionnaire included demographic information, nature of offence, relationship to the perpetrator, degree of coercion, duration, background history on the offender including criminal history, previous sex offenses, family responses, as well as a number of other issues related to treatment received, responsiveness.

2. Information on offenders was obtained from records of Child and Family Services for past and present cases. This examined the nature and type of offence, response of the offender, and other demographic and background information.

3. Offenders were interviewed in a group context as well as a number filled out a questionnaire including their perception of causality of the offenses, prevention for victims, how they were dealt with through the system, treatment services and effect of sentences on them.

4. A questionnaire was sent across the country to a number of sex offender treatment programs requesting that they act as key informants to assist in the development of a sex offender program. There were a total of 24 questions dealing with issues of sentencing, court process, treatment of offenders including issues of treatability and effective treatment.

5. A questionnaire was sent to personnel within the Department of Justice, more specifically Victim Services, Crown prosecutors and judges, which included within it information concerning training needs around issues of sex offenses, factors related to knowledge requirements for sentencing and issues and problems in the court process.

6. Information was obtained on issues of impact of sentencing, perception of treatment outcome, as well as suggestions for management from interviews held with child victims of sexual abuse and their families, professionals who treat offenders, and therapists who provide services to victims and families.

VI.2 RESULTS

Survey of Offenders

A survey was completed by probation justice personnel on a total of 44 offenders in 1989 and 1991. There were 6 adolescent offenders, 24 offenders ages 20-40 and 13 were 40-60, with one offender 74. The total sample was male with 8 being from Prince County, 31 from Queens County, and 5 from Kings County. Twenty-seven percent were married, 47% single, with 70% described as lower socio-economics class, and 25% middle class. Forty pleaded guilty to the charges and 3 pleaded not guilty. Eighteen received 90 days or less, 11 received 6 months to a year, with another 5 receiving between one and 2 years. Seven were given suspended sentences, one a conditional discharge, and one served a sentence between 2 and 3 years. Four received up to 6 months' probation, 12 received one year's probation, with 19 receiving from one to 3 years' probation.

The ages of the victims ranged from 0-6 (10%), 7-12 (23%), 13-17 (52%) and over 20 (17%). Eighty-seven percent of the victims were female. Thirty-four percent of the offenders were from within the family, with 16% being natural parents and 7% being step-parents. The largest category of offenders was offender acquaintance at 32%. The type of sexual misconduct included fondling, (34% attempted and/or completed), intercourse, (4 attempted or completed), penetration (3), exhibitionist (5), voyeurism (6), anal intercourse (1), for a total of 59 types of sexual offenses indicated. Physical force threat or verbal threat were identified in 8 cases, with psychological manipulation identified in 12. There were a total of 110 assaults identified, 23 cases having only one assault, 12 between 2 and 5 assaults, with 4 cases identifying assaults from 8 to 16 times, with 5 other cases described as numerous assaults. Eight cases were identified as assault on only one occasion, with 16 over 6 months, 7 from 6 months to a year, 3 from 2 to 3 years, and 3 for more than 3 years. Alcohol was identified as a factor in 48% of the cases and drug use in 22%.

Four offenders had received treatment previously, 1 for alcohol treatment, 2 at private agencies, and 1 at Mental Health Services. Six had previous sex-related offenses, 3 including sexual assault with fondling, 2 indecent assault, and 1 with charges laid and dismissed. Three had attended treatment specifically for sex offenses in the past. Twenty-three (52%), also had a previous criminal history with 9 having had charges laid against them in the last 9 years, 5 in the last 5 years, and 5 over the last 10 years. These charges included 6 for impaired driving, 4 for assault causing bodily harm, and 3 for assault.

Current Charges - Treatment

Response of the offender's family to charges included 10 denied the offence, 7 denied the seriousness of the offence, 2 blamed the victim, and 17 were accepting of the seriousness. Thirty of the 44 offenders were sent for an assessment, 14 were sent to a mental health clinic, 3 sent to Addiction Services, 1 to Hillsborough Hospital, 3 to the Queen Elizabeth Hospital, and 2 to private agencies. One was sent out of Province to Kitchener-Waterloo, Ontario. Twenty-nine were provided treatment after assessment, 14 of which went to the Youth Centre. Treatment included individual treatment (27), group treatment (8), marital counselling (2), and 2 received more than one type of treatment. Twenty-five (83%), followed through their treatment with 10 being seen weekly, 8 bi-weekly, 4 monthly, and 6 at other intervals.

The perception of change was that 18 had shown improvement, 7 had shown no change, and for one it was too soon to tell. The reasons given for no change were that 4 offenders were seen as unmotivated, 2 appeared to need more specialized intervention, one felt the problem was untreatable, and 1 felt the offender wasn't seen often enough.

The justice staff were asked to identify any systems factors that may increase the probability of the offender reoffending. It was felt that in 10 cases no court-mandated treatment would be a factor, poor coordination was identified in 2 situations, insufficient assessment resources in 2. Twenty-seven offenders were rated on their current level of functioning, and 5 were rated as low, 9 as medium, and 13 high. In terms of potential to repeat the offence, 16 were rated as medium potential and 8 were rated as high potential to repeat.

VI.3 INTERVIEW SURVEY WITH SEX OFFENDERS

Six sex offenders completed a survey form and a group of 5 sex offenders were also interviewed by therapists.

A. Related to Causing Them to Offend - Interview Offenders

Some of the areas identified were problems with self-image, marital difficulties, and confusion about their own life. One offender identified too close a relationship with his daughter and difficulties in his marriage, problems of assertiveness and issue of abuse during childhood was also identified, as well as overall feelings of powerlessness. Factors that affected one becoming an offender included issues of upbringing, society's attitude about women and sex. One offender thought that losing your self-respect was the beginning of becoming an offender. Another offender identified stressors in his life including unemployment, family stresses, and so on. Drinking and his own history of abuse were identified as factors. One offender felt that stresses in his life such as unemployment, marital problems and drinking were factors in his reoffending.

B. What Needs to be Done to Protect Victims and to Encourage Disclosure.

Responses include education of people around sex, especially at an early age, focused on children. One offender felt that it would be helpful for sex offenders to get help but also that people, especially parents, should know people before they let their children go around with them and that parents should teach kids to tell someone about it right away so it could stop it from happening. One offender felt that there should be more education about sexual abuse so that victims will feel free to come forward. One offender stated "Let them (victims) know that if they don't talk about it, that it will bother them for a very long time. It will effect their lives a lot." Another offender felt there needed to be more knowledge about what is a sex offence. Knowledge of how one could become a victim and situations in which it could happen should be highlighted.

C. Problems in the Way Agencies Dealt with You

Generally, offenders did not have a great deal of difficulty with the way they were dealt with by agencies. One offender stated that he felt that, after the police questioned him, they should have tried to get him some assistance as he was feeling very suicidal at the time. One offender felt that the judge did not notice the problems that the offenders had and needed professional help to correct it. It was also mentioned that there were not enough professionals to treat this problem. Another offender felt that the judge did not "notice" that he had a problem that needed professional intervention. He also felt that there was no way anyone can get treatment in jail as things stand now and that there is a general need for more trained therapists.

D. Court Sentences for Sex Offenders

Most of the offenders felt that court sentences were generally fair, with a few feeling that in some instances they perhaps were not severe enough. It was their feeling that it was important that the courts decide an adequate sentence to identify the seriousness of the crime; however, some felt that if the sentences were too severe this would create more bitterness in the offender and would not necessarily be helpful in the offender taking responsibility.

E. Changes that Could be Made in the Following Systems - Legal

Some of the suggestions that were made were that everyone should be treated fairly and it should not depend on your social status. Another respondent felt that it should be kept quiet and that, just because someone makes a mistake, they should not be condemned for life by society. One respondent felt that there was a need for more help for offenders and another felt that there should be treatment in the correctional center and that offenders should get help after the first offense. One offender felt there needed to be treatment available at the correctional centre.

F. Treatment

Most respondents felt that treatment was helpful, with 2 just starting therapy and 1 identifying it was somewhat helpful. It was felt that perhaps there should be more one-on-one basis, some finding the groups difficult. One respondent thought it should be available in the Charlottetown area rather than having to travel to Montague. Some of the helpful aspects of treatment were seen as making the person more aware of how to deal with problems and how to work them out; learning to open up and share feelings in dealing with problems; creating more awareness of yourself; utilizing journals to be able to change the way of behaving; someone to ask questions to, to understand things, to be able to notice a situation when it could happen again. One offender felt that treatment should be available immediately. Another offender felt that treatment was helpful in that there was someone to ask questions to and understand things.

VI.4 KEY INFORMANTS SURVEY - SEX OFFENDER PROGRAMS THROUGHOUT CANADA

Some of the agencies across Canada providing sex offender treatment programs responded to a questionnaire related to a number of issues in sentencing as well as providing treatment services for offenders. The questionnaire was broken down into a number of sections including jail sentences with offenders, sentencing, management of offenders, and treatment.

A. Jail Sentences

The study was interested in finding out the role of jail sentences in dealing with offenders. Respondents were asked about whether convicted offenders should serve sentences and what factors are important in determining this as well as the length of sentence. In most cases, the respondents felt that a jail sentence was appropriate, some feeling always to indicate the importance of accountability, seriousness of the crime; some with the proviso that without treatment it really doesn't have any impact. One program indicated that they would provide treatment as an alternative to incarceration. Important factors to consider in jail sentences included issues of dangerousness, level of denial, violence, type of crime (incest or rape), availability of treatment and so on. Prior history of offending, degree of force used, first-time versus second-time offenders, facilities available within institutions were factors important in terms of determining length of sentence.

The respondents were asked their opinion on whether or not longer sentences were considered a deterrent on the current case being sentenced. People who felt it was a deterrent usually felt that it wasn't effective unless there was treatment available and others felt that there was really no evidence that sentencing alone had a deterrent effect for most offenders. In regards to how it affects other offenders in the community, one person felt that it sends a clear message while others felt that offenders had problems that punishment alone will not cure. Others felt that the way that offenders rationalized and lack of empathy skills that the conviction of other offenders would not really have an impact upon themselves. Three felt that shorter sentences had the effect of encouraging more abuse as it gives the impression that this is a trivial and not a serious crime, while 3 others felt that it has little impact on other offenses.

Two respondents felt that current sentences that they have observed were too lenient and 4 felt they were just about right. The respondents were asked to identify the impact of various aspects of the justice system from the perspective of treatment and rehabilitation of offenders. These included:

(a) Going through the court system:

There was a split in opinion, some feeling that going through the court process forces the offender to deal with denial and seriousness of the crime and may help them with subsequent empathy work, while a few others felt that it would simply create resentment and have little impact upon the offender.

(b) Jail sentences:

It was felt that jail sentences did offer protection to society, identifying the seriousness of the crime, but that without some type of treatment available the ability to have any long-term impact was minimal.

B. Sentencing

The study was also interested in getting an understanding of what the court needed to assist them in the sentencing process. This included such issues as training requirements, information available to the court, length of sentence, and changes that might be needed in the criminal justice system to deal more effectively with offenders.

C. Training Areas

The respondents were asked to identify areas that they thought would be important for Crowns, judges to be more aware of in dealing with sex offenders.

D. Crowns

The primary training areas identified for Crowns were: the impact on victim, (both short-term and long), value and need for treatment/rehabilitation, characteristics and dynamics of sex offenders, value of sentencing, different types of offenders and the importance of mandating treatment.

E. Judges

It was thought that judges should be more aware of the availability of treatment resources, sex offenders' parole board process, recidivism rates, aspects of denial/minimization and dynamics of sexual abuse.

Respondents were also asked about what kind of information should be in front of the courts for sentencing offenders. Such things as evaluation by experienced/trained professional looking at causes and risk were important, issues around denial of offence, treatment availability, recidivism, motivation for treatment, history of sexual deviance, and so on. When asked about the length of sentence that would be recommended by these treatment agencies, there were several suggestions. One respondent suggested a minimum of up to 2 years, with longer sentences and release based on treatment progress. Another suggested a minimum of 9 months, long enough for treatment to begin in jail and to use parole as a motivator, especially for incest-type cases. Two years plus with violence for violent cases, and with compulsive child molesters long-term treatment, completed while in jail for safety to community. Another suggested 4 to 6 months for an isolated incident, with a lower degree of manipulation, with less harm to the victim, with two years less a day being given for sexual intercourse, use of threat or violence and threats. Another thought it depended on treatment and another respondent felt that, for low-risk clients, treatment could be used as an alternative to jail sentence.

VI.5 CHANGES YOU'D RECOMMEND TO THE JUSTICE SYSTEM FOR THE MANAGEMENT AND TREATMENT OF OFFENDERS IN REGARD TO:

A. Law Itself

The respondents identified a number of areas including breakdown of sexual abuse from the Criminal Code, mandatory supervised probation, making it easy for child witnesses to testify and easy to prosecute, continue to use victim protection shield, recognize that sexual assault is violent in itself and sentence should reflect this, and changing procedures for witness.

B. Police Investigation

Greater training in dealing with victim was identified, as was understanding that the victim's character has absolutely nothing to do with sexual assault, closer liaison with welfare agencies, victim impact statements completed, more female officers, and so on.

C. Crown Prosecutors

Greater sensitivity to victims concerned regarding testifying was reported, including access to psychological/psychiatric reports, more knowledge and training around abuse and available services, more knowledge of sex offending to seek appropriate sentences.

D. Judges

Respondents felt that there should be efforts made to ensure proper protection of victim from aggressive, offensive cross-examination. More standardized sentencing, presentence reports, general training, etc. Further suggestions were made in terms of correctional centres and probation officers (see Appendix "B").

E. Treatment

The respondents were asked about treatment services, including who should attend treatment, what should judges be aware of in sentencing offenders for treatment, what categories of offenders was treatment effective with and what are the important elements or factors involved in effective treatment intervention. Asked if all offenders should attend treatment, there was a general agreement, however, the importance of follow-up and coordination was identified and one respondent felt that voluntary treatment was the most effective way. In terms of ordering treatment, a number thought that the judge should take into consideration issues of motivation, factors of mental illness, intelligence, personality, availability of treatment, qualifications of practitioner of the program, and to be assured that the offender is getting treatment specifically for his particular problem area.

F. Groups and Types of Offenders

The respondents were asked about groups or types of offenders which might predict a positive/negative outcome for treatment. There were groups that would identify a positive outcome including incest-type, one victim/opposite sex, teen victim or on a few occasions, incest/first offence, responsible not isolated, no subsequent abuse; willingness to accept responsibility and ability to develop empathy. Others thought that there were offending patterns and offenders which would predict a negative outcome including the denial/minimization of the crime, degree of force, sexual intrusiveness, lower IQ, younger age, multiple sexual history of offence, exclusive pedophile interests, and so on.

G. Sex Offender Programs

Respondents were asked what were some of the most important elements required to develop a program for sex offenders effective. Nineteen suggestions were identified, including involvement of offender's family, motivation, qualified knowledgeable therapist, confrontation, group therapy, goal-oriented approach using cognitive therapy, dealing with life skills, and so on. The respondents were asked to identify any particular strategies that they utilized in providing treatment to a number of specific groups and also identify the problems that they might encounter.

H. Intrafamilial Offenders - Problems

Problems related to this area were close proximity of the victim to offender, offender and spouse playing each other off against the caseworker, difficulty in wearing different professional hats, sexual problems, and so on. Strategies that are used with this particular population are to develop relapse prevention programs, utilize group therapy, adjunctive psychiatric/drug/ marital/individual treatment, penile plethysmographic assessment, cognitive/behavioural, and so on.

I. Extrafamilial Offenders - Problems

Problems related to serving this population are: less ability to monitor behaviour of these offenders in that these offenders may be more likely to have personal sexual abuse in their history and be a possible regressive pedophile. Denial and minimization, resistance on the part of the offender and family, and lack of empathy are often issues. Strategies used for this population are repetitive, consistent confrontation, relapse prevention, group therapy, and so on. Respondents went on to identify other strategies that they are using in their programs which is included in the Appendix B.

J. Conditions of Treatment

The respondents were asked to indicate any preconditions they set for treatment. Several had no preconditions and would mostly work on the issue of denial initially. Sixty percent of clients in one program deny at first and they are able to get 60% of these to change their mind. When asked whether there were offenders that they thought should be treated in a closed setting, all respondents answered yes. These included those who constituted an immediate danger to the community and also have a high risk to reoffend. There were a few violent sex offenders that were identified as being never safe to release to the community and probably need indefinite sentences.

VI.7 INFORMATION - OFFENDERS

Information on offenders was collected as part of a review of 79 case records from cases previous to 1989 from Child and Family Services as well as information completed by Child and Family Services workers on 90 cases currently in the system from July of 1990 to March of 1991.

A. Past Cases

From the past cases, from 1986 to 1989, there were 93 offenders identified. Sixty-one involved intra-familial abuse with 27 being parental, 19 biological parent. Ten of these offenders were investigated previously with 9 charges laid and 9 convicted, with

5 attending treatment. All but 2 of the offenders were male. Thirty-five of the offenders were adolescents, with 37 ranging from ages 20 to 45. Thirty-three of the offenders were identified as having emotional problems, 27 marital, 19 alcohol, 12 problems with violent behaviour, and 10 sexual problems. Eleven percent were reported to have committed the act while under the influence of alcohol. Major type of offenses include fondling (53), oral-genital (33), anal vaginal intercourse (28).

B. Cases Currently in the System

There were 85 offenders identified for cases currently in the system since July of 1990. Fifty-eight of these were intra-familial abuse, 25 parental, with 16 biological parents. Eight of these offenders were previously investigated with charges laid against four, with 4 convictions. The 4 attended treatment. The type of abuse included fondling (53), oral/genital (24), anal/vaginal intercourse (17), exposure (12), masturbation (8), and sexual harassment (5). Thirty-six of the cases were identified as utilizing violence, coercion. All but 3 of the offenders were male. Twenty-three of the offenders were under the age of 20, with 43 being between the ages of 30 and 45. The offenders were identified as having a number of problems including marital (27), emotional problems (24), alcohol (21), violent behaviour (9), and sexual problems (7). Ten percent were reported to be under the influence of alcohol at the time of the offence. There were 25 charges laid, with 11 convictions.

The total profile of sex offender cases over the two time periods which includes the following:

	PAST	PRESENT
Number	93	85
Adolescent-	35	24
Prince County-	22	16
Queens County-	35	46
Kings County-	20	12
Intra-Familial-	61	58
Biological Parent-	19	16
Step Parent-	8	9
TYPE OF ABUSE		
Fondling-	53	53
Oral-Genital-	33	24

Anal-Vaginal inter-course	28	17
Exposure-	15	12
Other-	10	13
Violence/coercion-	58	35
Male offender	77	78
Female Offender-	2	3
Missing	14	4
Previous Sex Charges	9	4
Previous convictions-	9	4
Previous Sex Treatment	5	4
Charges Laid-	37	25
Missing-	15	21
Convictions-	34	11
Missing-	44	49
Probation-	24	8
Missing-	39	65

C. Family Interviews

As part of the key informant interviews with families of victims of child sexual abuse, questions were asked concerning their experience with the court process as well as impact of offender behaviour and sentencing. A total of 13 cases went to court. The decision of the cases were 1 no term, 5 probation, 1 acquitted, 1 sentenced 3 months but appealed, 2 charges withdrawn because child could no longer remember the details or the child was emotionally unstable to return to court, 5 of the offenders received probation with counselling, a total of 6 cases were ordered to attend counselling, and in 1 case compensation payment was ordered by the judge.

A number of respondents had difficulties in the way that the court process dealt with the offender. In a few cases, there was some ambivalence, especially in relation to intra-familial abuse, of the consequences to the offender and certainly some of the victims reported guilt feelings concerning their father being jailed. But on the whole, there was a general sense that the offenders were not held accountable and that sentences were light. Some mothers felt concern that there was not enough protection for them from the offender. One respondent stated, "I didn't want her to have to visit with him. They overruled this by asking her what she wanted, and of course she said, 'I wanted to see my dad, come and go whenever she wants.' I was told it was my job to watch that nothing happened." Some other comments included:

> "The sentence is completely inadequate for what he has done. I live a life sentence."
>
> "Extremely angry. He always controlled things and he wins again."
>
> "I felt despair because I thought he was going to get off scot-free."

Another respondent stated, "There should be a minimum sentence for a sex offence. The sentence should be longer. You get more of a sentence for stealing a car than for ruining someone's life through sexual assault."

Several respondents felt that the whole process was dragged out too long, which was detrimental to all involved. A few of the respondents felt that treatment should have been made available sooner. One respondent stated, "I felt the offender should have gotten help sooner. He admitted guilt and wasn't in court until six months later." When asked whether they had identified any changes in the perpetrator because of treatment, 4 respondents stated that they didn't identify any changes, with 4 others stating that the person demonstrated less anger, less pretence and less withdrawn. When asked whether they had identified any concerns or problems in the provision of therapy, a mother stated that there needed to be good counsellors and had run into some difficulty in the approach of some counsellors, that there were not enough resources including not enough experienced therapists and too many time delays. No contact with family, and the general denial of the perpetrator of his responsibility was also seen as a detriment to therapy. The Moms felt that, in order to improve the system, therapy should start right away and that it should be more available and regular and that family work and involvement should be more part of the process. One respondent felt that group therapy was not particularly helpful to the offender.

VI.9 OFFENDER SECTION - LITERATURE REVIEW

In reviewing available information on sex offenders, it appears that, even though there is a growing level of knowledge in the field, there is still considerable uncertainty about what motivates individuals to commit offenses and uncertainty about the best way to manage or treat. It appears that the main focus in the management and treatment of sex offenders is to reduce the risk of reoffending rather than focusing on cure. The report of the working group on sex offender treatment review for the Solicitor General of Canada identified the importance of assessing risk factors for offenders to reoffend. It is important to realize that sex offenders are not an homogenous group and that there is no single factor that explains or predicts the possibility of reoffending. However, there does appear to be some risk factors identified based on historical factors, especially information about previous offenses. These include prior sexual offenses, non-sexual offenses, multiple sexual deviancy, use of force, boy victims, men victims, strangers as victims, and exhibitionism. The working group identified risk factors in sexual offending that can be addressed by management and treatment programs, including:

(1) Individual disposition that remotivates sexual offending such as sexual desire, deviant sexual desire, emotional needs, conflict, i.e. dominance, hatred, and so on.

(2) Factors that serve to block the opportunity for normal sexual gratification, including unattractiveness, low IQ, unassertiveness, no social skills, restricted view of sexuality, sexual dysfunction, marital discord, and so on.

(3) Factors that can disinhibit and thereby promote acting upon deviant sexual fantasies, including alcohol, drugs, pornography, cognitive distortions, anti-social lifestyle, and so on.

(4) Factors that can inhibit deviant sexual arousal such as moral values, empathy for victims, aversion to violence, fear of consequences, incarceration, resistance of victims, and so on.

It appears sexual offenders can be differentiated in terms of the number and severity of these risk factors.

Some researchers focused on treatment and sex offender recidivism. Major studies were conducted in Britain, Denmark and Norway involving a 10-24 year follow-up of sex offenders. Of those 4,347 offenders who did not have any systematic treatment, 570 (13%), were reconvicted for sexual or violent offenses. Of those with prior sexual offenses, the recidivism rate was 28%. Child molesters had a lower recidivism rate of 14% than did rapists at 21%. Offenses against boys had a relatively high recidivism rate of 40%, although this finding was based on a limited number of offenders.

Studies were identified that used comparison groups to evaluate the effectiveness of treatment. A number of treatment approaches were used including comprehensive cognitive behavioural programs, recreation group therapy for probationers and so on. The 3 cognitive behavioural programs all showed significant treatment effects. Averaging across the studies, the sexual recidivism rate per offender was 10.2% while the rate for a comparison group was 25%. Studies do tend to move in the direction of predicting that treatment can be effective in reducing sex offender recidivism from 25% to 10-15%.

VI.10 DISCUSSION

Prince Edward Island, similar to the rest of Canada, has a considerable population of sex offenders which require intervention from a number of systems including Child and Family Services, police, the courts, corrections, and therapy services. In a program which is interested in providing safety, protection and healing to victims and families of child sexual abuse, the management of the offender creates many problems. From a societal perspective, there are general concerns about safety of the public and a sense of revulsion in regards to the criminal behaviour of this population. For some, it represents a serious criminal act that requires punishment, for others it is seen as a sickness that requires treatment. Within the community, the scenario of guilt and/or blame is acted out in an attempt to try to understand and deal with the reality of sexual abuse against children.

It is clear that the presence of the legal system and intervention into the lives of families and victims in order to protect children from offenses and to protect society from further offenses pulls the innocent parties through a process of investigations, court preparations and appearances which, even though required, in most cases are not a therapeutic experience for the victim and often interfere with the healing process. A good deal of time, effort, anxiety and resources are dedicated to this process. At the same time, there is a necessity for the offender to be held accountable, for the victim to be held blameless, and to feel that justice has been done.

Over the last several years, especially in the last two or three, these issues, dilemmas and controversies have been very apparent within the Island scene and have been a subject of great debate. There have been efforts to attempt to address some of these issues from the point of view of accountability, sentencing and the management and treatment of offenders. In order for an effective intervention into the problem of child sexual abuse, the management of the sex offender must be considered as a primary concern.

VI.11 CURRENT SITUATION - PRINCE EDWARD ISLAND

Over the last several years, various agencies have had to address the growing reality of the need to intervene with sex offenders. The knowledge and understanding of sex offenders and offenses has changed dramatically over the last several years. Each of the systems, from police, Child and Family Services, courts, corrections and therapy services, have all attempted to understand and address the need for intervention to the best of their abilities. At the same time, there appears still to be many difficulties and problems in that there is not any consistent, available, acceptable overall intervention in the area of sex offenses. Over the years, there have been some very positive initiatives and fervour of activity in this area, including training programs for workers and police, development of some protocol, establishment of some treatment services, attempts by the court to increase levels of specialization, and proposed initiatives for increased training services. At the same time, there still exists many gaps and inconsistencies and one could not say that we do have a coherent program in Prince Edward Island.

There are many advantages to developing a more consistent and focused approach for sex offenders. It appears that one of the major secondary victimization factors, especially for victims and families is the fact of having to deal with the court process. It would appear that, if there was a more consistent process from investigation through treatment, the ability to manage and provide treatment for sex offenders in a consistent, coherent fashion could reduce major pain and suffering for families and victims. The best possible scenario is one in which the offender is motivated to plead guilty, be made accountable for the crime, for the victim to be held blameless and not have to go through a court process, and for treatment and management of the offender to be made available as part of the scenario without at the same time compromising the rights of the accused.

In order for a more effective system to be put into place, there are a number of issues which will have to be addressed, including:

(1) Philosophical approach to offenders.

(2) Overall coordination of services.

(3) Training for all levels.

(4) Available assessment services throughout the Province.

(5) Provide available treatment services throughout the Province.

(6) The ability for long-term monitoring and management.

1. Philosophy

In order for any intervention into the management of sex offenders to be effective, there must be a coming together of the various interest groups to support a viable and potentially effective intervention for offenders. There is currently considerable divergence of views between agencies, professionals and community groups concerning the issues of offender accountability, sentencing, efficacy of treatment, and so on. In order for effective management of this population, there needs to be some "meeting of the mind" in regards to this population.

2. Coordination

There would appear to be a need for more developed coordination between various levels of intervention, including police, Child and Family Services, therapy, courts, probation, and so on. There are certainly examples in the Province where this has and does work well; however, there needs to be a more consistent development of protocols and approaches.

3. Training

It would appear that over the years there have been some efforts at increasing training levels from investigation to therapy; however, there needs to be more intensive focus in the area of training packages on each level of intervention and also training programs that will have the effect of being continuous due to change-over of personnel and so on.

4. Assessment Resources Available to the Province

There needs to be more available assessment services in the area of sex offenders and sex offenses. The aspect of a risk assessment needs a focus in regards to dangerousness, potential for treatment and treatment modalities. This needs to be available to the court previous to sentencing. Currently within the Province there is a very limited capability with only two therapists that have any particular training in this area and the availability of this resource in terms of time and accessibility across the Province is quite limited.

5. Availability of Treatment

Without the availability of adequate treatment and management programs, the overall system of intervention becomes ineffective. Based on an adequate and expert risk assessment, treatment programs and/or management programs can be identified and provided for some in-province and for others out-of-province based on need and difficulty with a combination of closed- and open-setting treatment.

6. Long-Term Follow-Up

There needs to be a recognition and a provision for long-term supervision and follow-up to this population. It would appear that treatment interventions do tend to reduce risk; however, it is also recognized that treatment alone without some long-term supervision will not show effective intervention for offenders.

Many of these issues identified will require further discussion and negotiation among the various agencies and parties involved. It is recognized that programs for offenders require an intensive level of training and resources based on the number of cases. The development of these services within a rural area is very difficult. Not only is it a resource problem but also an expertise problem. These are all important factors to be considered in the development of a rural model of services to victims and families of child sexual abuse.

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[1] Not all of the references listed are used in this section of the report. They were compiled as part of the proposal and are included here because they are relevant to this section.

VII. AGENCY STAFF AND PERSONNEL

VII.1 THERAPISTS:

Therapists are central service providers in child sexual abuse and two principal methods were used to find out about their perspective and needs. (1) In depth interviews with eight of the therapists most closely involved with work in sexual abuse were conducted that addressed their approach to working with child sexual abuse, their understanding of the needs and problems of different types of clients, their viewpoints about the work of the different agencies involved in providing service for sexual abuse, and their overall perspectives on the intervention system. On the average, interviews lasted about 4 hours. (2) A survey instrument was sent to those persons on the Island whose work involves some form of counselling or psychotherapy with clients with psychological problems. Since the purpose of this survey was to obtain a profile of possible therapy resources on P.E.I., surveys were sent to all available therapists including those in clinics and in private practice. With the exception of guidance counsellors who were sampled separately, all major "mental health" professions (i.e. social work, psychology, psychiatry) were included, as well as persons working in clinical contexts from other professions (e.g. nursing, occupational therapy). Surveys were sent to 46 therapists, and 45.7% of them responded (N=21).

This section will be divided into three parts. First,material relevant to therapists own experiences and needs will be presented. This will include the profile of therapy resources, therapists' background and interests in sexual abuse work, and what they identify as their training needs and needs for support in their work. Secondly, therapists' perceptions of other agencies involved in the sexual abuse problem and of interagency relationships and coordination issues will be presented. Finally, therapists' ideas about the major directions for change will be discussed.

1. Therapists - Profile, experiences and needs.

The Survey sample. Of the 21 persons completing the questionnaire, slightly more than half were female (57.1%), and all but one worked full time. They were quite experienced, with an average of 11.95 years of counselling and therapy experience. Most had Master's level training (66.7%) with the remainder having training at the doctoral (23.8%) or bachelor's level (9.5%). There were more with social work backgrounds (52.4%) than those from other professions, with 23.8% with psychology degrees and 9.5% each from both nursing and medicine/psychiatry.

"Formal" Training. Almost half of our sample (47.6%) indicated that they had received at least some training in sexual abuse in their professional schools. Far more

(80%) have had some type of "formal" training experience since their professional school education, most commonly workshops, . On the average, respondents had attended almost two ($\bar{X}$ = 1.85) training experiences. Most commonly, training sessions were 2 days long (46.8% of the experiences), but there were a substantial number (28.1%) of sessions three days or longer attended. Generally, the therapists found these sessions to be very valuable to their understanding and/or practice with sexual abuse with the mean rating in the moderately-extremely valuable range. The most common focus of these workshops and courses was on child sexual abuse or some form of treatment with victims and families (32.4%), or on adult survivors (27%), with 16.2% of experiences directed toward investigative-legal issues.

When therapists think of all of the training experiences they have attended on P.E.I., they appear to feel that the breadth of topics, and their relevance to the therapist's personal interests and to P.E.I. are all satisfactory (i.e. in the "good" to "very good" range). They would seem to prefer to see better follow- up to training experiences, rating this dimension as only "fair" on average.

Therapists appear to have had difficulty accessing these local training experiences. A large percentage (42.1%) indicate they have *rarely* gone to the training opportunities they have wanted to attend, while 15.8% indicate they have *sometimes* gone. A substantial number (26.3%) have often attended wanted training sessions, while the remainder (15.8%) have *very frequently* attended. The most common reason cited for limited participation in training was lack of time because of work demands. There is some perception within the agencies that access to training opportunities is not comparable for all members of the staff, and that it is more difficult for people who wish to *develop* skills in the areas to get support for attending workshops than it is for the existing "specialists" in sexual abuse within agencies.

Several therapists also noted how difficult it was to arrange to attend (and receive support for) more intensive courses and training off the Island. Such experiences were regarded as extremely valuable by those who had participated in them.

"Informal " Training. Therapists were also asked about their experiences with peer based and collegial forms of training in child sexual abuse. The large majority of therapists have had some experience with supervision (75.0%), case conferences (75.0%) and peer consultation (78.6%), while fewer have had co-therapy experiences (42.9%). Therapists have had comparable experiences in the number of cases in which they have had case conferences ($\bar{X}$=6.1), peer consultation ($\bar{X}$=7.1) and co-therapists ($\bar{X}$=6.0), but have had considerably more opportunities for supervision of cases ($\bar{X}$=13.0). Given the nature of the question asked, it is possible that therapists may have been responding to *attending* cases conferences where sexual abuse was the focus, and not just presenting their own cases. With the exception of co-therapy, these "informal" training opportunities appear to happen with some regularity and frequency about half the time, with the remainder being on an "as needed" basis.

Therapists find these opportunities to be highly valuable in their understandings and practices with sexual abuse. All are rated well into the moderately-to-extremely valuable range with supervision being regarded as the form with the highest value ($\overline{X}$=6.6 of 7), followed by co-therapy ($\overline{X}$=6.3), peer consultation ($\overline{X}$=6.2) and case conferences ($\overline{X}$=5.5). They regard these "informal" training experiences as being of approximately equal value to the "formal" training experiences they have had. They suggest that of the two types of training, "formal" training would be slightly more valuable to them in the future. Several therapists enthusiastically mentioned a "working with children in therapy" group that had developed over several years on an informal basis, and now included a number of people from a variety of agencies. This group now meets on a regular basis, with agency support for time off for workers to attend. Such a group would appear to be an excellent model for peer consultation, and deriving the full benefit from resources that exist within the community.

Work Experience. In their counselling work, therapists did much more work with adults than with other client groups. On the average, adults were their primary clients in 60.9% of their cases, followed by adolescents (18.2%), families (10.3%) and children (8.7%). It is unclear from these data whether the small amount of work with children is a function of opportunity or preference. However, therapists in interviews pointed to the relatively small number of people with specialized competence and interest in treating children in the province, a major source of concern for sexual abuse work.

When therapists are asked to select two descriptions that best characterize the work they do most often, they most commonly endorse short term intensive counselling (n=14), followed by long term intensive counselling (n=8) and crisis management (n=7). When asked to select categories that best describe the work they felt trained to do, the results are basically comparable with some small, but interesting differences. Several more therapists (n=11) feel trained to do long term intensive therapy, while fewer (n=5) feel trained to do crisis management work. This finding supports an observation made by several therapists that they felt the clinics seem to be encouraging more short term work, in part through expectations that each therapist take on a comparable number of new cases per month. The concern was raised repeatedly that the resolution of sexual abuse is a more long term process, and some counsellors had "solved" their problem by simply carrying a larger caseload (e.g some carry 65-80), and seeing their long term cases less frequently than they felt were necessary.

This sense of a " constant pressure to take new cases" seems to be a real dilemma for therapists. While they generally do feel supported in their work at the clinic level and rarely appear to be actively encouraged to terminate cases, they struggle with perceived clinic policies on equitable caseloads and open door policies with referrals. One felt that "there are other cases that could be held off longer that aren't as high a priority." Furthermore, sexual abuse cases are regarded being intensive and demanding because of the multifaceted nature of the work (work with children, families, children and families together), the time needed for interagency coordination, and the depth of the hurt and vulnerability of the children. As one therapist suggested "This is the place where we must do our very best work." Therapists are left often feeling that they have little time for much consultation about cases, like clients must always be "jammed in" that they see clients less frequently than clients need, and that they often lack time to do more than minimal work with families.

Experiences with sexual abuse cases. Many therapists have had at least some experience in providing forms of treatment for different aspects of the sexual abuse problem. Most therapists have at least some individual counselling experience with female adult survivors (71.4%), and with child or adolescent female victims (61.9%). These two forms of treatment are also identified as the types they have most frequently provided during the past two years. Many therapists have also done individual work with adult male survivors (52.3%) and with nonoffending parents (47.6%), and surprisingly substantial numbers have at least some individual experience with adult offenders (38.1%) and adolescent offenders (33.3%). One-third (33.3%) of the sample had some individual experience with child or adolescent male victims, with the lowest level of experience being in aspects of family and group work. In adult work, sexual abuse is quite common in the clients they see. Only 36.9% of therapists indicated that it was present in 10% or less of the cases they see, while 36.9% of therapists identified it in the histories of more than 20% of their cases. Using midpoints of distributions, it can be estimated that approximately 23% of the average adult caseload of surveyed therapists involved sexual abuse.

When therapists are involved in child sexual abuse cases, the child is most commonly their primary client (72.2% of the cases) with mothers/nonoffending parents being the focus 15.1% of the time. Families are the focus only 5.4% of the time, and offenders in 7.3% of the cases. For most therapists (61.7%) sexual abuse cases comprise a relatively small proportion of their child and adolescent caseload (i.e. 10% or less), while for a smaller, but substantial number of therapists (27.0%), these cases make up more than 40% of their caseload for these groups. Furthermore, only five therapists identified seeing a child in counselling as their most likely course of action when encountering a sexual abuse case, compared with 14 who would make a referral. As expected from other sources in this study as well, a relatively small core of therapists are devoting more of their therapeutic attention to sexual abuse cases.

Knowledge, training needs and interests. Therapists were surveyed about these three areas as a further means of helping us to assess therapy resources in the community. Table 7.1 presents therapists' ratings of their own level of knowledge of different aspects of the sexual abuse problem. They rate their overall level of knowledge of child sexual abuse in the "moderate" range ($\overline{X}$=4.6 out of 7), with their highest levels of knowledge in female adult survivors, crisis management skills, behavioral/physical indicators and legal issues. They see their knowledge as least well developed in the areas of adult and adolescent offenders and for very young child victims. Almost all ratings are in the "moderate" range.

Therapists rate their need for more training in sexual abuse as close to moderately high ($\overline{X}$=4.9), and Table 7.1 (same as above) also presents their rankings of which areas are most valuable for their personal training. Table 7.2 presents their levels of interest in working with different aspects of the sexual abuse problem, as well as their rankings of the areas that they regard as the major priorities for sexual abuse treatment. Their highest levels of interest involve individual work with child and adult victims, and with nonoffending parents, with interest in family and group work in the "moderate" range, and work with offenders having the least interest to our sample. However, therapists' lists of priorities recognize the need for group work with groups for female and male children being among the four highest rankings, along with individual work for female children and adult survivors.

Overall, therapists rate their level of interest in working with sexual abuse as "moderately high" ($\overline{X}$=5.4), and most frequently endorse little background training,heavy caseloads and insufficient ongoing training opportunities as the most important reasons for their limited involvement previously. To become more involved in the future, they would need more opportunity to attend specialized courses off of P.E.I., smaller caseloads, more time to attend local training opportunities and more agency support to spend enough time on sexual abuse cases.

(2) Therapists' Perspective and Experience with Other Agencies.

The previous discussion of victims' experiences with intervention incorporated the perspective of therapists principally as key informants about children and families . In this section, the focus will be on the therapists own perspective and experiences with other agencies in the intervention system, and will include material on interagency relations and coordination. Since it is difficult to separate a discussion of these issues from the clients therapists counsel, there will be some material more related to victims' experiences included here as well. The principle aim will be to identify needs and problems therapists see in the work of these different agencies, and in their interface with therapy.

Police. Therapists' perspective on police involvement with children and families in the process of investigation seems to reflect the "it all depends theme". Generally, it seems to depend on "two guys", although several other officers are mentioned by respondents as well. There have been many positive comments about sensitive and knowledgeable police response from a variety of informants during the course of the study, more commonly about the RCMP about whom most respondents have more information. Positive comments about the same two officers come up repeatedly; one therapist commented that "parents are often very impressed with ________; he's very sensitive and supportive". One city officer is commonly mentioned as well. With other officers, the response is to sexual abuse seems more uncertain, and therapists perceive some considerable discomfort with sexual abuse investigations, and the problems that come from not having an adequate knowledge base about sexual abuse itself or investigative techniques with children.

Obviously, such a concentration of effective resources creates considerable gaps when they are unavailable. Therapists feel a need for more development of specialized teams and training for officers. They would like to see "designated kid cops" as well as more knowledge generally in officers that interview abused children. One indicates that parents of preschool children have had particular problems with police investigations since their children are too young to give evidence.

Social Services. All therapists have had extensive experience with Child and Family Services. This agency is the most common source of referral for therapy cases, and therapists often continue to be involved with members of both the child protection and the long term teams. Therapists concerns about referral and particular workers were discussed earlier. Therapists generally feel that they have good working relationships with Social Services, and all seem to have at least several workers with whom they can comfortably and confidently consult. Workers in the agency are regarded as being very sensitive to children, and having good cooperation with therapists. While therapists generally feel quite positively about most front line workers, they also voice concern about the considerable amount of worker turnover within some offices in the department. When this occurs, it appears that therapists may regard both client outcome and interagency relations as highly unpredictable.

A number of therapists commented upon the "unrealistic " caseloads that workers had to carry, and it was noted that the department "does a good job of managing risk; [they're] not paternalistic." These caseloads might also be related to therapists' observation that they sometimes felt that more time needed to be spent on some investigations. Therapists felt that there was a need to develop more centred investigative methods and suggested that attention to some of the "smaller things" with children and families (e.g. providing coffee, transportation, using dolls) could be helpful.

Therapists saw major gaps in the areas of communication and support and follow up of cases. Some therapists note that there is sometimes little contact with workers after referral, when collaboration with Social Services could be very useful. Within the therapy community, there is also a perception that Social Services is sometimes reluctant to involve others in decisions, and that the "ownership" they may feel with a case may contribute toward a limited process of consultation. It was suggested that they need to coordinate with therapists more and to more actively seek their input.

There is certainly some conflict of mandate between the therapy and social services system, and one study respondent noted that therapists might need to better appreciate the child protection mandate. Similarly, another suggested that child and family services workers may need to accept that treatment isn't their mandate as part of a more fruitful collaborative relationship with therapists.

Crown Attorneys. Many of therapists views of the different justice system agencies were incorporated into the discussion of victims' experiences of court, so the material presented here will be brief. Generally, therapists felt that there was not enough time for interviews with the child. The concern was raised that other agencies might be taking on aspects of work better done by the Crown. "They should be more of a figure in the life of this child; too much of their work is translated by others". Workers were rated as far more sensitive to children than the protocols and procedures of the office. Therapists would like to see more of a cooperative relationship developed with the Crown, and the "rushed" aspect of preparation that therapists mentioned when discussing victims' experiences sometimes applies to Crowns' relations with therapists as well. Abrupt changes in dates and times, last minute notice of court appearances and requests for help were mentioned as some sources of frustration in therapists' work.

As mentioned earlier, many positive comments were made about the appointment of a special Crown prosecutor for sexual assault, and the improvement in many aspects of response to clients and to other agencies was commonly noted. Therapists were encouraged by her consultation with counsellors and with the increased use of expert testimony. But reliance on"one woman", like "two guys" raises some serious questions in the assurance of a quality response.

Victim Services. By and large, Victim Services is seen as playing a very positive role in relation to children and families, and victim impact statements are seen as very powerful in court. They are seen as having very good communication, and are very responsive to therapists' needs. The major issue in their practice seems to concern some confusion about where they fit in the process of child witness preparation and support.

Court. As the previous discussion indicated, therapists have many concerns about the response of the court to children. They see the need for considerably more sensitivity, knowledge and flexibility in court procedures and personnel if the court process is to be less traumatic for children. The court is perceived as somewhat separate and inaccessible, and therapists report their difficulty and frustration in their attempts to bring their knowledge of sexual abuse to the court in their testimony. Sometimes they feel that they are unable to discuss very important aspects of the child's life, or key dynamics of sexual abuse. They are concerned that judges might not regard the need for specialized knowledge in sexual abuse as particularly important. They see a very strong need for education of defense attorneys and judges in the effects and dynamics of sexual abuse.

Therapists also see a need for the court to develop better patterns of communication and cooperation with them;. They cite examples of not being informed of changes in dates, having to rearrange their schedules on short notice, and sometimes not being called to testify after doing so. They are troubled by either the erratic or lenient quality of sentencing in relation to the message it communicates to sexually abused children.

Therapy agencies. Since most of the therapists in our interview sample were drawn from the public agencies, it is difficult to develop an "outsider's" perspective on the community mental health system. Certainly, therapists have identified many needs and problems within the therapy system. They identify therapy resources as in the "poor-to-fair" range for all clinical groups, and therapists' level of skill and competence ranges from almost "fair" to almost "good" for the different client groups.

We noted some significant gaps in communication and the exchange of information among therapy agencies. Within the community mental health system, therapists do not always have a clear idea of the nature of work that therapists in other CMHC's are doing. Victim and offender therapists in different clinics often seem unfamiliar with each others' work. This applies with the private clinics as well, where there may be gaps in communication and information in their relations with the public clinic workers.

The two private agencies make and receive referrals for therapy for different aspects of the child sexual abuse problem. Catholic Family Services had done very little work with children at the time of this study, and provided therapy for some parents and adult survivors. Protestant Family Services did work with some child victims and developed a contract with the province for adolescent offender treatment, in addition to seeing some parents and survivors. Therapists perceive waiting lists, particularly with the latter agency to be a problem, and generally feel the need to have these agencies and the workers within them, more integrated and involved with others doing sexual abuse work.

One further comment relevant to therapy resources deserves note. One therapist, while discussing adult survivors observed that:

> ***There are still people afraid to touch it.***
> ***Clients bring it up and some therapists***
> ***don't want to talk about it.***

In relation to this observation, this therapist discussed survivors who had been made to feel that they were mentally ill by psychiatrists. While there were several favourable comments about psychiatrists made among the adult survivors, and some support on their behalf of work with adult survivors, they do not appear to be part of the functional therapeutic community for child sexual abuse. Only one therapist mentioned a psychiatrist as a person to whom she would make a referral.

Rape and Sexual Assault Center . This is a community organization with its roots in the women's community that provides crisis line counselling for child and adult sexual assault victims, and individual and group counselling for adult survivors. Crisis line workers are mainly volunteers and one staff member works principally as a counsellor with survivors. They refer calls to Child and Family Services when reporting is required, and receive referrals from diverse sources (e.g. doctors, psychiatrists, addictions, mental health clinics) for adult survivor work.

As with the private agencies, a number of therapists have not had direct experiences with this agency. Among those that do have experience, counsellors appear to be of divided opinion about their work. Some counsellors speak very positively about their level of sensitivity, cooperation and impact on clients. They are regarded as very responsive to the needs of victims, as very supportive to mothers and victims on an ongoing basis, as a very needed resource, and as having played a leading role in public education and training for professionals in sexual abuse. Almost all therapists interviewed identify the Centre's counsellor as a person to whom they would refer adult survivors, and the agency is also occasionally mentioned as a referral source for mothers. Other therapists raise concerns that the agency may not respond well to cases that don't fit with their conceptions, and note the presence of tension between them and the professional community. One therapist noted that they have much more credibility in the community with female than with some male therapists because they are identified as a feminist organization.

This divergence of opinion seems to reflect the considerable philosophical differences between the public, mental health agencies and the "grass roots" women's community organizations, who approach the sexual abuse problem quite differently (in addition to having different kinds of workers and funding arrangements). Each has developed their own services without much communication with or knowledge about the other, and there appears to be some mutual wariness on an interorganizational level. It is noteworthy that a some therapists in the clinical community were unfamiliar with the Services for Adults Survivors, a program being developed out of the Centre that would take a major role in adult survivor counselling.

So between these organizations there appears to be a considerable gap that needs to be overcome if all community resources are to be effectively utilized in responding to all aspects of sexual abuse. And while this study has focused principally on the needs of child victims, the need for collaboration and mutual support among the public and community agencies is essential if the needs of adult survivors are to be effectively addressed. As one therapist put it:

> ***We need to start talking between the groups. We're going to have to talk to one another sooner or later to deal with some of the crises in services.***

Perhaps if all agencies who worked with sexual abuse were more explicit about their understandings, philosophy and assumptions about the problem, the basis for better collaborative relations could be more firmly established.

Anderson House. As the shelter for battered women and their children, the workers at Anderson House are very familiar with the experience of violence. On occasion, mothers and children will seek shelter here after a disclosure of sexual abuse has been made, and workers at the house will provide supportive resources for the family.

One worker has also provided some group counselling for sexually abused children.

Therapists are extremely appreciative of the nature and quality of services provided by Anderson House. Although all have not had direct experience with this agency, it generally receives the most favourable ratings for sensitivity, knowledge and impact on children. As one counsellor put it, "I feel better about them than any other agency here." Another indicated that "children I have worked with really feel good about Anderson House." It is regarded as a very needed resource in the community, and one worker in particular is commended by several therapists for her sensitivity and advocacy with children - the "one woman (or two guys)" theme once again. It was suggested that this agency may sometimes be "unrealistic in terms of moms' strengths", and may have some difficulty with the conflict that some women would feel about returning to their abusive partners.

Generally though, therapists regard Anderson House as being very positive with mothers and often observes that it is "one of the few organizations who have tried to set up support groups for moms." They would like to see this agency become more involved in the response to child sexual abuse.

Therapists views of agencies: A brief summary. From the therapists' perspective,the major issues, problems and needs in the response to sexual abuse seem to center around the following themes:

1. **It all depends**. The response to sexual abuse can be unpredictable. It is dependent upon many contingencies outside of the control of the child, most notably mandates and particular workers.

2. **"Two guys (or one woman)"**. Trained and effective workers are few, and resources are extremely concentrated. This leaves the child very vulnerable if those few trained people are unavailable. This is very much of a rural problem where resources are limited. It becomes even more of a problem when workers and clients are uncomfortable with those limited resources that are available.

3. **Lack of communication and coordination within and between agencies**. Therapists and other workers don't always know what each other is doing, and need to develop integrated, coordinated and child centred means of addressing this problem.

4. **The need for time and training** across the service community to develop sufficient specialized knowledge to respond effectively to sexual abuse.

What's needed: Therapists suggestions for change:

> ***I'd like to see it come as far as addictions on P.E.I. in terms of money and services.***

> ***I'd like to see child sexual abuse in a similar position. Sexual abuse is seen more as a women's issue so there's less focus on it.***

Therapists clearly feel that child sexual abuse needs to become a priority both within the agencies that deal with it as well as for government generally. In their minds, resources rather than rhetoric is required to begin to address this very disturbing problem.

> ***The system's verbal commitment [must] be met with a comparable practical commitment for protection and restoring kids to good mental health. We need the commitment of trained and knowledgeable workers. Workers have been rendered impotent with unrealistic caseloads and excessive demands.***

After reflecting on all the different aspects of intervention, therapists were asked to identify the several features most in need of change in the system's response to sexual abuse. The following represent the major themes they provide in directions for change.

1. There needs to be a **coordinated, interagency team approach** to dealing with sexual abuse cases. Given all the persons and agencies involved in responding to sexually abused children and their families, and all the problems engendered by such extensive service system involvement, it is not surprising that almost all therapists mention the need for such an approach. To address the need for coordination, they may refer to the need for all workers to share information, the value of group decision making, the use of case management, the importance of a coordinated approach to treatment, or the need for an interagency interest group to share experience/expertise. What is evident in these different suggestions is the need for a coordinated approach, one that has the child at its center with some commonness of purpose.

> ***Those agencies involved need a general philosophy on how certain kinds of cases should be handled. [We need] consensus on how we're going to take care of these kids...a coordinated approach from beginning to end.***

2. **"Quality treatment available to each sexually abused child"**. Therapists understandably emphasized the importance of good therapeutic services for children and their families as part of a ***"continuum of services from education to intensive psychotherapy."*** The need for individualized and developmentally appropriate therapy experiences was stressed spanning the range of modalities from play therapy to more intensive individual work. Most commonly mentioned as a gap in the services available, and as an area of great need, were therapy groups for children and adolescents.

3. **More therapeutic opportunities for mothers, non-offending parents and families** are needed. One therapist called this a *"desperate need"* and another suggested, *"you have to meet the needs of moms to meet the needs of kids"*. Therapy needs to be available for mothers to deal with their own personal issues, in addition to their supporting and enhancing involvement in their child's therapy. Work with families may involve dyadic work with the victim and non-offending parent, including siblings more in the therapy process, working on safety issues and structural change in those incest families that do reunify, or in meeting needs of families in cases of extrafamilial abuse.

4. There needs to be **more specialized training in investigation** for police and social services that uses the most *"up to date"* , and least intrusive investigative methods. As indicated earlier, this is one of the areas of intervention where therapists perceive their clients to have the greatest difficulty.

5. There need to be **changes in the justice system** to make it more child centred. Considered as a group, this may be regarded as the therapists' highest priority for change. Court is seen as quite *"anti-child"* and therapists put considerable effort into dealing with its impact with their clients. Among the many specific suggestions offered are child advocates who testify on the child's behalf, using videotape, screens, the use of more experts in court, education and information for Crowns and judges, and more use of designated Crown specialists. The confusion about responsibility for preparation of victims for court also needs to be addressed. In one therapist's words, court has *"a long way to go on P.E.I."*

6. There needs to be **support and advocacy for children and families.** *"You need a real child oriented person who goes through it all"* with them. While therapists are seen as important sources of support, it is acknowledged that other sources of ongoing support are needed. Most therapists regarded the idea of self-help or mutual aid groups as quite useful in providing such support, and such groups were seen as an adjunct to therapy rather than as a substitute for long term counselling.

7. There needs to be **more education of the public.** Several areas were mentioned here, including the need for immediate actions and reactions of belief to disclosure, the need to inform people about the effects and risks of sexual abuse, and the need to do preventive work with young men (e.g. in babysitting courses) at an age where they may be more likely to become young offenders if unaware of feelings they may have in contexts with young children.

TABLE 7.1
LEVEL OF KNOWLEDGE AND PERSONAL TRAINING

	Level of Knowledge		Ranked Value for Personal Training[1]
	Mean rating	Rank	Rank
dynamics and treatment of adult survivors (female)	$\bar{X}=5.3$	1	2(t)
role of other service agencies	$\bar{X}=5.2$	2(t)[*]	13
crisis management skills	$\bar{X}=5.2$	2(t)	15
behavioural/physical indicators of child sexual abuse	$\bar{X}=5.1$	4	14
legal issues related to sexual abuse	$\bar{X}=5.0$	5	10(t)
dynamics and treatment of child and adolescent victims (female)	$\bar{X}=4.5$	6	2(t)
dynamics and treatment of non-offending parents in families with incest	$\bar{X}=4.3$	7	8
dynamics and treatment of child and adolescent victims (males)	$\bar{X}=4.1$	8 (t)	5
dynamics and treatment of adult survivors (male)	$\bar{X}=4.1$	8 (t)	4
dynamics and treatment of families where incest has occurred	$\bar{X}=3.9$	10 (t)	1
investigative interviewing skills	$\bar{X}=3.9$	10 (t)	10(t)
dynamics and treatment of families where extrafamilial abuse has occurred	$\bar{X}=3.8$	12	9
dynamics and treatment of very young child victims	$\bar{X}=3.0$	13	6
dynamics and treatment of adolescent offenders	$\bar{X}=2.9$	14	7
dynamics and treatment of adult offenders	$\bar{X}=2.8$	15	10(t)

1. Overall rankings for value for personal training were derived by assigning weights to rankings of each individual respondent (1st=5, 2nd=4, 3rd=3, 4th=2 and 5th=1) and summing across all respondents. The descriptors below reflect the groupings of the total scores for the sample. Ranks 1-4 are of very high value. Ranks 5-9 are of moderately high value. Ranks 10-15 are of low value.

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[*] t denotes a tied rank.

TABLE 7.2
LEVEL OF INTEREST AND PRIORITIES FOR TREATMENT

	Level of Interest		Ranked Priority for treatment[2]
	Mean rating	Rank	Rank
individual counselling for female adult survivors	$\bar{X}$=5.9	1	4
individual counselling for male adult survivors	$\bar{X}$=5.4	2	9(t)
individual counselling for child/adolescent female victims	$\bar{X}$=5.2	3(t)[**]	1
individual counelling for child/adolescent male victims	$\bar{X}$=5.2	3(t)	3
group counselling for female adult survivors	$\bar{X}$=5.1	5(t)	9(t)
individual counselling for non-offending parents	$\bar{X}$=5.1	5(t)	16
group counselling for child/adolescent female victims	$\bar{X}$=4.7	7	2
mother-daughter dyadic counselling in paternal incest cases	$\bar{X}$=4.6	8	11(t)
group counselling for male adult survivors	$\bar{X}$=4.5	9(t)	13
family therapy in extrafamilial cases	$\bar{X}$=4.5	9(t)	17(t)
group counselling for child/adolescent male victims	$\bar{X}$=4.4	11(t)	5
group counselling for non-offending parents	$\bar{X}$=4.4	11(t)	17(t)
family therapy in intrafamilial paternal incest cases	$\bar{X}$=4.3	13	6
marital counselling in families where parental incest has occurred	$\bar{X}$=3.5	14	14
individual counselling for adolescent offenders	$\bar{X}$=3.2	15	8
group counselling for adolescent offenders	$\bar{X}$=3.0	16	11(t)
group counselling for adult offenders	$\bar{X}$=2.3	17	7
individual counselling for adult offenders	$\bar{X}$=2.2	18	15

2. See previous Table for method of deriving ranks. Ranks 1-4 are of high priority. Ranks 5-8 are of moderate priority. Ranks 9-18 are of low priority.

[**] t denotes a tied rank.

VII. AGENCY STAFF AND PERSONNEL

VII.2 JUSTICE

1. Justice Survey:

A survey was sent to Victim Services, crowns, and judges. Six surveys were completed. The survey was designed to give some general directions in regards to issues and needs in the justice system as they relate to child sexual abuse cases. It was not meant to be an overall evaluation but simply some directions and suggestions from key informants about areas that may need to be addressed on further investigation.

When asked how many cases of child sexual abuse the respondent has dealt with, it ranged from a low of 4-6 to a high of 100. When asked to compare how complicated or complex child sexual abuse cases were as compared to other cases that they've dealt with, four identified them as much more or somewhat more complicated, one about the same, and one much less complicated. Four respondents felt that there was a need for some specialized knowledge in dealing with these cases. Some felt that the multifaceted problem of dealing with physical and emotional safety of the child as well as the family issue and the issue of credibility, laying of charges, need for counselling, and so on make these cases more complicated, recognizing that no one case is ever the same. In terms of specialized knowledge, one respondent felt that training in the area as well as understanding of the court process was extremely important and, if a worker does not understand that process, then the victim will be much more confused. Another respondent felt that there was a need for specialized knowledge; however, probably no greater than some of the other areas of law. Another respondent felt that specialized knowledge and information about reactions of children to sexual abuse could come through the utilization of expert witnesses. One felt that there was a specialized area in terms of children having to be assessed as witnesses, bearing in mind that they are children and not adults. One respondent felt that, if any training was needed, it would be regarding child psychology on how they answer questions and view the world at certain ages rather than specifically regarding sexual abuse itself. One respondent felt that there was psychological/ psychiatric evidence relevant to many cases.

Respondents were asked for information concerning overall knowledge required to provide services through the court system. It appeared from the initial survey that many of the respondents had taken courses in areas of sexual abuse from dynamics of sexual abuse to knowledge of adult offenders and offenses, adolescent sex offenders, and so on. Some of the areas of interest for further training included general knowledge about child development, physical behaviour indicators of sexual abuse, dynamics and roles of families in child sexual abuse, availability of assessment, treatment services for victims, families and offenders, and impact of abuse on the child.

Further areas identified included how developmental issues impact on children's recall and testimony, preparation techniques for child witnesses, interviewing skills with children, crisis intervention with families, impact of treatment on offenders, impact of age on understanding/competence. The indications of further training were not identified among the number of respondents as a major need as in most cases only one or two respondents identified areas of need of further training. One respondent identified that some of the need for information and knowledge may be specific to certain areas - for example, lawyers who will be examining child witnesses, or issues dealing with psychological development of children and how they react - and this could be brought out by expert evidence during the trial. Other items were viewed outside the jurisdiction of justice. Impact of sentences and treatment of offenders could be brought into the court through expert witnesses at the time of sentencing. In terms of the best format to provide the information, training, experience, such ideas as seminars, skills training, workshop format, lecture handouts were suggested. One respondent suggested bringing professionals in with expertise in the area and have small workshops with role-playing and lots of participation.

Respondents were asked to rate, on a scale of 0 - not a problem, 1 - minor problem, 2 - moderate problem, 3 - major problem, 4 - I don't know, a number of problems and issues which had been identified locally and through the literature related to provision of legal services to children. Some of the areas highlighted included length of time to go to court and to complete cases which four rated as a moderate problem, one a major problem, and two not a problem. The court system is not child-centred - four rated a moderate or major problem. Too many barriers to prosecution - three moderate. Court procedures aren't flexible enough for child witnesses - three moderate, one major. Prosecution of child witnesses with very young children - three moderate, one major. Availability of specialized treatment services for victims - three moderate, one major. Availability of specialized treatment services for offenders - three moderate, one major.

One respondent felt that the length of sentences to go to court was a moderate problem but compared to other parts of Canada it appears to be quicker. Two respondents felt that there has been an improvement in many areas related to sentencing, use of expert witnesses, specialized knowledge and training.

Respondents were asked to make suggestions as to what can be done on Prince Edward Island to address those issues which they had identified as major or moderate problems.

Issue No. 1 - Length of Time to Go to Court

One respondent felt that more training available about the investigative and for police officers to assure charges can be laid as early as possible. Another respondent suggested educating all involved about the importance of time.

Issue No. 2 - Length of Time to Complete Cases in Provincial Court

It was felt that perhaps hiring another Supreme Court judge would be of assistance as well as the problem of delaying tactics used by lawyers, especially when the case has to go to Supreme Court, causes a great deal of difficulty. Another respondent stated that judges could decide that child sexual abuse would take priority over other cases and set the earliest possible court dates at all stages including motions, appeals, etc.

Issue No. 3 - Court System Not Child-Centred

Respondents stated that there needs to be booster seats available with separate waiting area for children while waiting. Another respondent felt that, because of the rights of the accused, this could be hard to really change at the provincial level but some other cases might help, e.g. closed-circuit TV, increased use of screening, and so on.

Issue No. 4 - Inadequacy of Victim Impact Statements

One respondent felt that statements are not consistent with some victims more articulate than others. Also, statements tend to reiterate the evidence and this is not their function.

Issue No. 5 - Use of Expert Witnesses

It was felt that the court could have expert evidence regarding psychological development of child of the particular age of the victim to assist in assessing his or her evidence. Also, should have expert evidence regarding the physical/behavioural indicators of sexual abuse.

Issue No. 6 - Police Investigations

It was felt that perhaps more intensive training in this area would be useful.

Issue No. 7 - Courts Not Flexible Enough For Child Witnesses

One respondent suggested educating judiciary of the frailty of children and the effects on children of the present court process.

Issue No. 8 - Availability of Specialized Treatment Services for Victims

It was felt that there is required a more trained staff at Mental Health to handle these cases as well as treatment of offenders. One respondent felt that are very few therapists who worked with young children and those are booked solid and often have a two or three-month waiting list. It is felt that these services are not readily available and accessible and that parents and children need them as soon as possible. One respondent stated, "Hire more trained therapists, this area is exploding." One respondent highlighted the issue of the court open to the public, stating that children were very upset over this.

Issue No. 9 - Treatment Services to Offenders

One respondent suggested to invest more money in this area.

The respondents were asked to rate how much the following were a problem on Prince Edward Island. Included are those items rated as a moderate to major problem by three or more respondents.

(1) Length of court process (4).

(2) Delays, postponements (5).

(3) Fear/anxiety as court approaches (4).

(4) Cross-examination by defence counsel (5).

(5) Facing the accused in the court before the trial (3).

(6) Court environment intimidating to children (3).

(7) Court is open to the public (3).

(8) Understanding and accepting non-guilty verdicts (3).

(9) Accused out on bail contacting the victim (3).

(10) Removal of the victim from home rather than the accused (4).

Respondents were asked to rate a number of suggestions to help address some of the problems that are experienced in the court system. The following is the list of suggestions which were rated from "I agree a little" to "Strongly agree", with the number of respondents in each category:

(1) Development of private waiting space for victims (5).

(2) Use of privacy screens for child victims (5).

(3) Give precedence on schedule for children for child sexual abuse cases (4).

(4) Permit use of videotaping of testimony (4).

(5) Eliminate the corroborative requirement and enact an ability to communicate test (4).

(6) Allow a supportive adult to sit with the child during testimony (4).

(7) Allow a child witness to have breaks during testimony (5).

(8) Provide a booster chair for child witnesses (5).

(9) Provide microphones for child witnesses (5).

(10) Use of closed-circuit TV (5).

(11) Use of expert witnesses concerning the impact of abuse on children (5).

(12) Use of expert witnesses concerning ability of child witnesses to testify (5).

(13) Use of orders to prohibit accused from contacting the victim (5).

(14) Use of court orders to remove accused from home rather than the victim (5).

The respondents were asked for any other ideas that would help make the legal process better for child victims. The following are some suggestions:

(1) There is a great need for more crown prosecutors with training in this area. There was emphasis on comfortability of the crown with children and also the availability of the same-sex prosecutors.

(2) The concept of working in teams was identified as important. Teams could include RCMP, Victim Services, Social Services, and crown prosecutor. Each could help with particular duties and therefore no duplication.

There was a sense that presently there are sometimes too many people involved in a case and that the atmosphere for the child is overwhelming. This respondent felt that a three-person team would be ideal.

(3) One respondent felt that the use of a privacy screen would be very good; however, had problems with the closed-circuit TV, feeling that it is important for the judge to have full view of the witness to get a full appreciation of the evidence. Also, it was stated that sometimes the thing that may be of assistance to the victim, such as adult sitting with the victim, may be open to challenge by the defence of coaching and credibility of testimony.

(4) There should be rejection of newspaper coverage of testimony or facts of sexual abuse. It appears that this tends to exploit and sensationalize cases.

(5) There needs to be more crown positions available so the preparation time of these cases can be increased.

(6) There is a strong need to familiarize the child with the process and the physical outlay of the court. It is important that children present information to the court through their own language and not to utilize medical or legal terminology as it may appear as if these are the words of others rather than the child himself.

(7) Hire more people for all stages of the process.

As stated at the beginning of this introduction of survey information, this is not in any sense meant to be an extensive review of the court system on Prince Edward Island. It is recognized that it represents the views of six respondents; however, it does give some areas of direction and suggestion that may be followed up through the justice system.

2. Victim Services:

Victim Services provides assistance to victims of crime. it is staffed by one coordinator and two workers. One worker provides services to Prince County with the coordinator servicing Charlottetown and the other worker servicing rural Queens and Kings. The service has been playing an active role in assisting victims and their parents, most often moms, in such areas as emotional support, information about child sexual abuse as well as preparation for court, development of victim impact statements and referrals to other agencies. The whole program services approximately 800 persons per year with about 80 (10%) being victims of sexual abuse and of these 32 (40%) being victims of child sexual abuse. The largest referral source if from the Queens County area.

Some of the major needs identified were that victims need to be believed, moms need support and understanding especially when the abuser is the spouse, the victim needs information about what is going on in court and where things are in the court process as well as the victim's need for special help in understanding the court process.

Victim Services felt that the establishment of the "special Crown" is working very well. It was felt that sexual abuse cases have always had a high priority but more so now. Investigation techniques have improved, and the understanding and patience of judges is good. The assignment of police for specialized training was seen as positive but there is need for more.

Some of the gaps identified included:

1. **Access to services for victims, families and offenders** not available consistently across the province.
2. **Not enough resources** to provide the needed assessment and services.
3. **More specialized staff** required in treatment.
4. **Need for better support** for the non-offending family members.
5. **Need for agencies to have more knowledge and awareness** of the court process.
6. **Long delays in court** due to a number of procedural factors such as including preparation by all parties involved, delaying tactics by the defence and so on. As such, it appeared that due to this it was important to priorize these cases to reduce the impact of other factors.

3. Crown Attorneys:

Interviews and meetings with both of the two special prosecutors for sexual assault provided the basis for the discussion of their needs and perspective. Data were gathered on their views of victims and their own work, on other agencies and workers involved in the sexual abuse problem, and on their suggestions for change. Contacts with the first Crown occurred relatively earlier in the project, and her perspective is not always presented with the same level of detail here because of the nature of our interviews with her.

Work with victims. Crown attorneys speak about the fragility of the victims and the difficulty of their going through the court process. They recognize the trauma of testimony and cross examination, and how difficult delays are for the child. And while delays are regarded as a part of the system that is necessary for the gathering of evidence and defense tactics of preparation, time was described as one of the major problems of the court process. It was also suggested that time was one of the easier problems to address.

Because of the vulnerability of the child victim, Crowns take more care in their preparation than they would with other witnesses, who they would rarely see before the day of court. They try to prepare child witnesses to testify even if they suspect they might not be called. Children may generally be seen "once or twice", and it was noted that with more preparation, the child becomes more comfortable and a more effective witness. More details may also emerge with more preparation. Sexual abuse cases are regarded as very demanding of time and expertise, and often take as much time as a murder case to prepare.

Crowns described themselves as being in the position of having to balance the victims needs with society's needs in doing their work, and didn't feel that the public was always sensitive to this dilemma. In each case, they had to think of the precedent set for future cases and experiences of victims in court, in addition to the current child. Since "bad cases make bad law", they felt a need to be careful about the cases in which they made arguments for certain measures (such as the use of screens) so that a poor precedent was not established.

Public pressure from "interest groups" seems to heighten this dilemma for Crowns, and there is the perception of a public desire for stiffer sentences that is felt to not always serve the victim's interests very well. For example, a victim might have difficulty testifying or a family might be accepting of a "lighter" sentence, but a Crown might be very reluctant to seek a sentence such as probation with treatment because of this pressure. Furthermore, the desire for longer sentences is seen as contributing to more "not guilty" pleas and therefore prolonging the court process. Police officers also now appear to routinely consult with Crowns about charges, even on relatively minor cases, because of the fear of making a mistake on these cases. In fact, the first Special Crown for sexual assault was hired after such a visible mistake was made by another attorney, so the reasons for such wariness and care are evident.

Another major problem perceived by the Crown is the absence of incentives for quick settlements and guilty pleas by the accused. "If they plead guilty, they've lost all their leverage." Furthermore, since the court doesn't recognize much of a difference between pleading guilty immediately or waiting until shortly before the trial, delays are very much in the interests of the accused. More needs to be done to encourage the offender to plead guilty, and to do it quickly to help the victim avoid the trauma of waiting and/or testimony. But the public pressure around sentencing may be felt to make it more difficult for Crowns to settle cases in ways that would speed the process (e.g. more use of probation with treatment).

Other agencies and workers. The Crown Attorneys work closely with Victim Services which is seen as a "big improvement in the system," and experiences with other agencies are described as good. Consulting relationships are available with mental health and social services personnel, and Crowns are comfortable with and interested in using expert witnesses. One described the current court response to sexual abuse as " generally reasonable, given the fact that you're dealing with the system the way it is, given the fact that it's adversarial,." and sentences were described as "getting better." Judges' knowledge and response to the problem was also seen as improving, and the example was used of how judges now expect some inconsistencies in children's testimony, and are not disturbed by it.

Suggestions for change. To address some of the major problems in the legal response to sexual abuse, the following suggestions were made.

1. **Commit extra resources** into every aspect of the problem to effect change.

2. **Use a "generalist-specialist" approach**, i.e. make sure that there are at least several well trained persons in an office (e.g. police detachment, Crown) so that there will always be a well trained person available to respond.

3. **Quicker time frames** could be established with mutual commitments to change this problem from police, Crown and the court.

4. **Educate society and interest groups** about the Crown's dilemma in trying to meet the needs of victims.

5. **More use of offender treatment** in sentencing and more effective collaboration with Corrections so that treatment could occur during incarceration.

6. Need **specialized training opportunities for Crowns and judges** that are most relevant to legal issues and the impact of sexual abuse on children. Judges were felt to find training opportunities and analysis of court problems from judicial colleagues to be the most meaningful and relevant.

VII.2 JUDGES

The Rix Rogers' report, Reaching for Solutions, has outlined a number of suggestions for the courts in an attempt to reduce the victimization of children who have been sexually abused. These reforms try to eliminate the barriers to testimony for children. They included among other things the corroboration requirement, "ability to communicate" test, the use of video taped interviews and screens. The pace of implementation of these suggestions has varied between and within provinces.

Judges provide a unique perspective on the needs of children, indirectly and directly because they are both observer and participant. In the same sense, they have a perspective on the needs of the court and themselves as participants in the process. Judges in the Provincial and Supreme Courts were interviewed to gain another perspective on the needs of children and the justice system. They proved to be insightful and represent good suggestions for the Justice System.

At first glance, judges felt they did not have in essence, a direct knowledge of the victims and their needs before and during court as they are not seen before the court process begins. The major vehicles for the expression of the victims needs in court are the Prosecutor, and if there is a conviction, the victim impact statement.

The Crown must establish the need effectively for the victim in order to permit testimonial aids such as screens and videotaped evidence as a means of allowing "a full, candid and cordial" account of the abuse. Although it is within the court's discretion, the prosecution must demonstrate this requirement in order to assist the child.

Screens are being utilized more frequently in courts in P.E.I. Video-taped interviews are now permitted under the Criminal Code, but their role as evidence is still unclear and rate of implementation is slow. Judges feel they should be done properly when collecting evidence, thus avoiding such problems as the perception of interference with the testimony. Judges feel to some extent that it should be viewed as supporting evidence. There are still many questions about its role in a child's testimony.

Victim impact statements are another means for a victim to communicate different aspects of their situations and needs, but its actual role is in the sentencing of a convicted offender. This appears late in the court process. Within the Criminal Code its role or use in determining sentence is unclear. Judges were to some extent uncertain about how much weight or influence they should have. They felt they have an impact, but how much they should have is unclear in the Code. What judges seem to identify as important is both the content and presentation. This increases its effectiveness.

Although support services are available, they felt they should be used as frequently as possible. They appear to help, but it may be a question of available resources. Other research has suggested that a more active support person should be available to the child in the courtroom. One who ensures the victim is not intimidated without prejudicing the rights of the accused. Judges feel this is done frequently by them, especially with defense attorneys. The obvious question is whether judges can play more of this role in a non-prejudicial manner or is more support required. The issue should be more fully explored.

Suggestions have been made that courts should modify the rules of evidence affecting "hearsay" evidence and "previous consistent statements" and allow witnesses to testify on a child's "out of court" statement. In addition, the court should allow more "expert" witnesses (social workers, and therapists, etc.) to testify on the reliability of children's statements and to explain certain aspects of a sexually abused child's behavior and that of young children. To some extent the feeling was that there is a need for more explanation.

It was felt that judges have some discretion as to the admission of evidence in terms of such things as other child witnesses, or "reasonable time" after the abuse when the evidence was collected and by whom. The question that was raised was how much discretion and what was "reasonable". Again, the question of evidence was raised.

In terms of the admission of "hearsay" evidence, it was felt that the court is doing this more frequently in cases involving children, although perhaps not as fast as many would wish. They felt that it was still a very "grey" area. It would be best with good corroborating evidence. One judge felt that the fear of admitting certain kinds of evidence can increase the possibility of retrial which forces the victim to go through the entire process again. This appears to be a constant dilemma in courtroom decisions.

The question of court delays and its effect upon victims has constantly been raised in the needs assessment. It was felt that the Provincial Court seems to have little delay in scheduling. It was pointed out, however, that more cases are moving to the Supreme Court by waiving the preliminary. The feeling was that the availability of provincial court can be changed simply by legislation.

In the Supreme Court, dates are to some extent a function of the Jury Act which provides for two sittings per year, six months apart. This is apparently in the process of being reviewed and changed. In essence, more court dates will be open. What is required is that more be set aside for sexual abuse cases involving children. However, the recommendation was that good data is required for long term projections from either Social Services and/or Police to help set aside a sufficient but not unnecessary number of dates. This would help in preventing delays. It is typical for attorneys to want at least two months for court preparation. Delays are also a function of consensus on the part of the parties - the crown, defense and judges.

Suggestions have been made that prosecutors should have a higher degree of specialization in child sexual abuse cases. This has also been extended to judges. It may be a good idea in the short term, but may prove to be ineffective in the long term. Based upon their experience with Family Court judges, the possibility of burnout is high which can lead to judicial ineffectiveness. The preference was for more specialization among the judges themselves. The general feeling was that a number of judges hearing such cases is good for the system.

In terms of specialization, it was felt that judges have been requesting more education by experts. It was noted that one seminar was scheduled this fall on criminal law with child victims, prosecution, etc.

Judges see some need for the use of more expert witnesses, but it is still the Crown's role to establish the need. At present, there is no problem with admissibility of their evidence. It is a matter of the rate of acceptance. The concern was for good expert witnesses and preparation. One concern was raised with regard to the similarity of their testimony.

In some urban areas, there have been suggestions for a Code of Ethics for attorneys when dealing with child victims and children who testify. The feeling was that judges are fairly aware, and set limits. Likewise, lawyers at present have been fairly conscientious. It was pointed out that to some extent, protecting the victim's rights and treatment in court is partially the role of the prosecutor.

The media often have a role in the victimization of the child. At present, according to the Criminal Code, a ban on publication is at the discretion of the judge. Although routinely used, the value of the ban was questioned in terms of its effectiveness. The major comment was that one way or another, the community or the media find out anyway. The concern is with how to remedy this situation.

With regard to sentencing, the major feeling was on the uncertainty as to the level of effectiveness of sentences. In other words, judges felt a need for information on the outcomes of sentences, not just precedence. The only way one knows a sentence has a real effect is that one does not see the offender in court again. The inclusion of treatment in sentences had very mixed reactions - there were concerns about both effectiveness and access.

Judges were concerned with the effectiveness of treatment. This caution was based on a lack of information regarding when it works, how well, what types, in what situations and with whom. Second, the comment was that there were too few programs available.

In terms of a convicted offenders, judges felt that treatment may be part of a sentence, however how and when do they get access to treatment? Their feeling was that they never know. Some feelings were to avoid treatment in sentences and leave it to the offender to seek help. Questions were raised about the guarantee of access if treatment is required.

The possibility of "experimental" sentencing similar to that found in Alberta which uses delayed sentencing, and Ontario, which uses delayed pleas was discussed. In other words, either is delayed while assessment and treatment commence. If the outcome is favorable, a short or no jail sentence is imposed. There is probation with strict conditions for treatment. If the outcome is unfavorable, the convicted offender returns to court and a further jail sentence. The results appear to be effective and to reduce recidivism.

There was much discussion on this topic and conservative interest. It is legally feasible in P.E.I. The concerns were, does it work, and can one force treatment? P.E.I. may not be ready and the immense amount of coordination required, especially in delayed pleas, may not be feasible in the Province at present.

Young offenders were discussed. Judges felt very restricted even in imposing treatment in sentences. The Young Offenders Act requires the consensus of three parties for treatment; the offender, the parents and the facility. It was felt that the Act and its constraints should be reviewed.

When asked, what is a "good" case for a victim, one response was - prosecution which is specialized, good relations with the victim, good preparation and a good witness. Most important, the major need is good evidence.

The final comment reiterates what has been found in various parts of the needs assessment. The system, especially Justice, is a highly interdependent process within itself and with other agencies. Good evidence starts with good reporting and then coordinated, skilled, and cooperative investigations as the process of intervention then begins to proceed.

VII.3 LAW ENFORCEMENT OFFICERS

VII.3a CHARACTERISTICS OF RESPONDENTS

Respondents to the law enforcement survey in Prince Edward Island were both Members of the RCMP and Municipal Departments. They ranged in size from a Detachment with twenty-one members to one with six members. Municipal departments ranged in size from thirty-two to two officers. Approximately, forty-three percent (43%) are municipal and fifty-seven percent (57%) are Members of the RCMP.

Of the one hundred thirty-eight respondents (138), 72% have responded to this date due to the high level of cooperation within the Municipal departments and the RCMP detachments. By the end of the project, the response rate will be at least 85%, with near equal response rates from both types of law enforcement agencies. Rates would be somewhat higher, however, except for vacations, in-service training, transfers, and the like. The projected response rate was approximately 90%. Consequently, the response rate is very good to excellent in comparison to other law enforcement surveys.

Officers averaged almost twelve years of experience with a standard deviation of eight years. Thirty percent (30%) had five or fewer years experience, thirteen percent (13%) had six to ten years, forty-five percent (45%) had between eleven and twenty years of experience, and twelve (12%) had twenty-one to thirty-five years of law enforcement experience. The respondents' distribution of rank was in general categories; 79% Constables, 12% Corporals and 9% Sergeants or Staff Sergeants.

The respondents had an average of 9.7 years of municipal patrol experience with 25% having five years or less. The average years of criminal investigation experience was 5.4 years with 60% having fewer than 5 years. Highway patrol in the RCMP averaged 3.7 years, with 76% having fewer than five years experience. In terms of general detachment duties, the average was 8.4 years with 47% having fewer than five years experience.

Officers and Members tended to have been in their current location for an average of six years. However, the median (50% point in the distribution) was three years in their current location. Sixty-five percent (65%) of the respondents were fewer than five years. In general categories, 27% of the respondents were in general patrol duties as their current position, 8% highway patrol (RCMP), 4% criminal investigation, 55% general detachment duties, and 5% FES, Drugs, etc.

Officers and Members averaged 4.6 years in these positions, however the median was two years. Seventy-four percent (74%) had fewer than five years experience in those duties. The average age of the correspondents was thirty-five years old with a standard deviation of seven years. Thirty-two percent (32%) were thirty or under, 50% were between thirty-one and forty, and 18% were between forty-one and sixty years of age. Nine percent (9%) of the respondents were females and

91% were males.

VII.3b SEXUAL ABUSE EXPERIENCE

Officers and Members varied significantly in their experience investigating child sexual abuse cases in the past two years. Of the ninety-nine respondents, forty-three respondents (43%) had experience as a principal investigator in 220 cases, which is approximately an average of six cases. This, however, is slightly misleading because eight respondents had been principal investigators in 135 cases. In other words, 14% of the respondents had investigated more than 60% of the cases. The distribution as principal investigators is to a great extent bi-modal in nature; little experience in the past two years and a lot of experience.

Law enforcement officers may not only be the principal investigators in a child sexual abuse case, they may assist in an investigation. Forty-two percent (42%) of the respondents had not assisted an investigation in the past two years. Of the approximately three hundred assists (two or more officers may assist on an investigation), 58% had assisted in five or fewer cases - most on just one or two. Seventeen officers had assisted in 74% of the cases. In other words, they had assisted in between six and more than forty cases.

Since officers and Members change duties frequently, they were asked to generally estimate how many cases they had investigated in their career. This would give us a better sense of their overall experience, including the past two years.

TABLE 7.3
Cases Investigated (Career)

Number of Cases	Number of Respondents	Percent
1 to 5 cases	32	32.3
6 to 10 cases	11	11.1
11 to 15 cases	7	7.1
16 to 20 cases	5	5.1
21 to 25 cases	3	3.1
31 to 40 cases	2	2.0
60 or more cases	5	5.1
no cases	34	34.3
	n = 99	100.0

From the preceding table we realize that 64% of the respondents have very little or no experience in the investigation of child sexual abuse and fewer than 10% has a considerable amount of experience. Despite this fact, any officer can be called upon, depending on circumstances, to begin or to assist in an investigation of sexual abuse.

To get another sense of law enforcement officers' experience with child sexual abuse, they were asked if they had laid charges previously. The laying of charges brings an added dimension to an officer's experience and responsibility to a case. Twenty-three percent (23%) of the respondents had laid charges previously. Those officers had laid approximately two hundred charges. Five officers had been responsible for nearly 65% of those changes. Again we see a bi-modal distribution in the amount of experience, and a large majority of officers having no experience in charges being laid. This would obviously affect their orientation toward collecting evidence and other aspects of investigation and prosecution requirements.

When we examine the joint distribution between principal investigators and assisting investigators, we gain a better picture of the distribution of experience. As stated before, 57% had not been principal investigators and 42% had not assisted an investigation in the past two years.

In a rural area, the distribution and availability of this experience in the investigation and laying of charges becomes critical in child sexual abuse cases, as it does for experienced social workers, prosecutors, judges, therapists and other professionals.

VII.3c EXPERIENCE - JURISDICTION AND INVESTIGATORS

If we use contingency table analysis to examine experience and location we realize that, as one would assume, the higher levels of experience as principal investigators (10 or more cases) are concentrated in the urban municipal departments and detachments. Of the 220 cases investigated, six officers had been principal investigators in 62% of those cases. The remainder are still urban, and those officers with experience in six to one investigations were scattered in rural departments or detachments. This creates a very thin distribution of experience.

Of the nine female officers, five had been principal investigators. Two officers in four cases, two in two cases and one in one case. In other words, they were principal investigators in 5% of the cases.

When we examine the distribution of principal investigators and experience, we find that the majority of cases have gone to officers with the ten or more years experience. However, approximately 20% of the principal investigators had fewer than five years experience and most had done a few cases each. In terms of assisting investigations, the lower numbers were distributed proportionately to all departments and detachments. Again, the higher number of assists were associated with urban departments or detachments. A small number of assists, however, were done in rural areas. Female officers contributed in 4% of the reported assisted investigations. Officers with fewer than five years experience assisted in 16% of the cases, usually one or twice. Again, the majority were done by the most experienced officers in the urban areas.

In terms of career investigations in child sexual abuse, 34% had no experience. The lack of experience was fairly equal in the urban departments-detachments - 30% of the officers. In rural areas, the lack of experience ranged from 40% to 70%. If we examine experience in fewer than five cases, all departments range from 10% to 25%. Depth of experience again seems to be concentrated in urban areas, however, no criminal experience tends to be concentrated in rural areas.

The laying of charges by areas was fairly uniform at between 15% to 23%. Twenty-three percent (23%) of those reporting charges laid were done by officers with less than five years experience. Again, most charges laid were done by officers with ten or more years of experience. One trend constantly emerges in terms of law enforcement experience. That is, being a principal investigator, assisting, and laying charges does not appear very frequently among officers with six to ten years of experience.

This section has given some sense of the distribution of experience in child sexual abuse cases. Given our previous findings, approximately 65% of the cases in P.E.I. were rural in nature by residence or the location of the offense. Experience and depth of experience is to some extent concentrated in the urban areas. We should note, however, that RCMP urban detachments do serve some rural areas in Queens and Prince Counties. Our concern, however, in the needs assessment is the distribution and availability of that experience in rural areas. This will be discussed in more depth in later sections.

VII.3d PROBLEMS IN INVESTIGATIONS

Officers must be willing to investigate all criminal complaints. As with professionals in many fields, people will feel "comfortable" or "uncomfortable" with doing certain tasks, especially in sexual abuse cases. The reasons are quite varied. When asked, nearly 80% of the officers felt comfortable doing child sexual abuse investigations, 21% of the respondents didn't answer. When asked, "how comfortable?" - 11% said sort of comfortable, 48% said fairly comfortable and 21% said very comfortable. Of the 20% who indicated they are uncomfortable - 18% said sort of and 3% indicated fairly or very uncomfortable doing sexual abuse investigations concerning children.

Respondents were asked how frequently they encountered cases where children were unwilling to provide any details in an investigation. Thirty-four percent said they never had a case of child sexual abuse. Of the officers who had cases, 27% said they never had that difficulty, 58% said it happened once in awhile, and 15% indicated a lot of the time or always.

They were also asked how much difficulty they had in collecting evidence from young children. Seven percent (7%) said none, 6% said very little, 37% said some difficulty, 15% said quite a lot and 7% said with extreme difficulty. These two items obviously indicate that officers have varying experience and difficulty with children and collecting evidence.

To pursue this in greater depth with officers and members, a battery of questions were asked. Each respondent was to rate their own adequacy of knowledge and skills in each area of dealing with children and children who had been sexually abused. The following table summarizes the data from that battery of questions.

TABLE 7.4
Skills and Knowledge

	Very Ade-quate	Quite Ade-quate	Some-what Ade-quate	Some-what Inade-quate	Quite Inade-quate	Very Inade-quate	Total n
a. interviewing children	2%	30%	52%	11.5	3%	1%	96
b. collecting/documenting evidence	4%	29	52	9	3	2	96
c. dealing with children's fears during an investigation	3%	36	40	17	2	1	96
d. determining the validity of children's statements	2%	33	36	23	0	2	95
e. building rapport with children in an investigation	2%	34	40	20	1	2	96
f. determining what is an adequate interview with a child in terms of time, depth, etc.	2%	34	41	20	1	2	96
g. introducing the purpose of the investigation with a child	1	34	49	13	1	2	97
h. establishing the need to tell the truth with the child	11%	47%	35	5	1	0	97

	Very Ade-quate	Quite Ade-quate	Some-what Ade-quate	Some-what Inade-quate	Quite Inade-quate	Very Inade-quate	Total n
i. using interview aids (pictures, etc.)	3	30	37	25	3	2	97
j. using non-leading interview techniques with children	5	22	42	26	3	2	96
k. understanding the developmental stages of children, their language and how they respond	4	20	43	28	2	2	97
l. recognizing the behavior indicators of children who have been sexually abused	0%	12	42	35	8	2	97
m. recognizing the physical indicators of child sexual abuse	2%	11	46	32	5	3	97
n. understanding the family dynamics of sexual abuse cases	1%	11	41	37	6	3	97

OVERALL RATING OF SKILLS/KNOWLEDGE							
a. with children	1%	37	44	11	2	1	96
b. with children who have been sexually abused	1%	27%	43%	25%	3%	1%	89

As we examine relationships between experience as a principal investigator and assisting in cases of child sexual abuse we get a better sense of available experience in these cases in Prince Edward Island. As we noted previously, more than 50% of the officers had not been a principal investigator in a sexual abuse case and nearly 50% had never assisted in an investigation in the past two years. In addition, 34% had never had a case in their career.

The experience of both appears to be concentrated in a number of select officers in urban areas which provide some service to rural areas. When we combine career cases and experience in the past two years we find that a large percentage, nearly 45%, have neither experience in the past two years. This is then combined with career experience which is nearly the same percentage. What is important is that most officers with experience have minimal. Both those with minimal experience and no experience are heavily distributed in rural areas.

There are, as stated before, several exceptions where officers with a moderate level of experience are in rural areas. The difficulties that arise in some rural areas, and sometimes urban areas, are availability of those officers due to a host of reasons - transfers, vacations, sickness, training, case load, on-going investigations and the like. These situations increase the possibility that an inexperienced officer, one with no training or low levels of both, will be assigned to a child sexual abuse investigation because of personnel shortages. This type of situation which occurs frequently will increase the difficulties in an investigation, the coordination with social workers, and then the eventual outcomes for both victims and families.

VII.3e PROTOCOLS

Officers and Members were asked about varying aspects of the Child and Family Services Act and protocols because of its influence on the investigation of child sexual abuse complaints. Seventeen percent (17%) of the respondents felt they were quite or very familiar with the CFS Act, 35% felt they were somewhat familiar with the Act, and 47% indicated they were slightly or not familiar.

In terms of the protocols between police agencies and Social Services in the investigation of child sexual abuse complaints, 54% of the respondents indicated that they were aware of the protocols; 46% were not. Of the officers who were aware had only recently become aware of those protocols in the past 3 years (67%), twenty percent (20%) were in the last year. Again, of the officers who were aware, 50% had little or no understanding of them, 30% had some and 20% had a lot or fully understood the protocols. Of the aware officers, 26% felt they were totally useful, 72% felt they were somewhat useful, and 2% felt they were not useful.

Despite awareness and usefulness, officers are expected to follow those protocols despite the difficulty they have with them. Thirty-seven percent (37%) of the officers had no difficulty with the protocols, 28% had a little and 35% had some or a lot of difficulty. Consequently, 48% of the respondents (n = 50) who used the protocols, felt they had followed them a lot or always, 26% had followed them some of the time, and 26% indicated that they had following them a little or not at all.

Officers described the major difficulties as primarily the lack of detail in direction in certain situations. Some felt contacting Social Services was difficult at times. In some cases officers felt that social workers were unaware of the necessary evidence needed in an initial interview in order to proceed to court, or of the protocols themselves.

One of the more interesting comments by officers was that they were hard to explain to parents. Therefore, we may at times find difficulties in the cooperativeness of families during investigations.

The important factor in the needs assessment is that protocols influence coordination and cooperation which, as the research has indicated, can directly or indirectly affect the victim and family. As a consequence, victims may be increasingly victimized and even become less cooperative to either the police or social workers. Obviously, protocols and the adherence to them should be reviewed with the goal of making them more operative and increasingly to contribute to the coordination between police and social workers.

VII.3f PROCEDURES AND REPORTING

Police typically have special internal procedures they may follow during an investigation of sexual abuse cases. Fifty-five percent (55%) of the officers indicated they had procedures, 26% said no and 19% said they didn't know if there were procedures to follow. Despite the number who said no or didn't know, 85% felt that they understood those procedures.

Obviously police officers can't do everything independently and need some form of supervision at times. Given the complexity of sexual abuse cases and young victims, officers were asked if they need or would need supervision. Fifty-nine percent (59%) said yes. When asked if they felt it was adequate in these cases, only officers with experience could answer the question and 74% felt it was adequate.

Officers were asked how frequently they report a number of different types of information to supervisors in sexual abuse investigations. On what may be considered minor offenses (e.g., exposure), 37% were daily, 15% were weekly, and 36% were monthly. In major offenses according to the criminal code, 53% were daily, 11% were weekly, and 30% were monthly or bi-monthly.

Officers were asked their opinions about the investigation of sexual abuse complaints. First, they were asked if these types of complaints require an approach in terms of style and attitudes that was different from other cases. Ninety-eight percent (98%) said they felt they did. Of course, how different should the approach be? Most officers (51%) felt the approach should be very different, 41% felt it should be somewhat different and 8% indicated slightly different from other types of investigations.

Recognizing that victims in sexual abuse cases have different needs (99% of the respondents), they were asked how different. The majority of officers (71%) felt they were very different, 25% felt somewhat different than other victims, and 4% said slightly different.

Lastly, officers with experience in these cases were asked how well they had responded to the needs of victims. Their responses varied. Eleven percent (11%) felt very adequately, 38% quite adequately, 39% somewhat adequately, and 13% somewhat to very inadequately.

Officers obviously recognize that the needs of victims and investigators are different and require a specialized response. That response will be a function of training, supervision, and investigation procedures.

VII.3g COORDINATION WITH SOCIAL SERVICES

Since officers can spend a considerable amount of time with social workers during their investigations, they were asked a number of questions about coordination and related factors. Ninety-three percent (93%) felt that there is an active role for social workers in investigations. Some officers (27%) felt they should understand the criminal code more fully and possibly (23%) have a better understanding of the methods and procedures of criminal investigations. In addition, 25% felt that social workers should share more information about victims, although they shared information about offenders frequently.

Officers seemed to be concerned that social workers should share their roles more frequently (35%) and they should have more access to workers after hours (56%). In general, however, they rated their communication with Social Services as good to excellent (61%) and 36% as fair - their overall cooperation as good to excellent (70%).

What is apparent is that most officers feel that the working relationship is good between them and social workers, but, there are areas for improvement of their relationship. Likewise, as we will note later, social workers have identified areas of improvement in coordination. What should be of concern to the needs assessment, is that relationships during investigations are excellent and the need is for a fuller understanding of each role. If this is the case, then the probability of re-victimization and additional disruption to the family is decreased.

The expectations on an officer's work directly influences how they fulfill those roles in conjunction with a wide variety of people - victims, families, prosecutors, supervisors and others. The respondents were asked how realistic or unrealistic those expectations were based upon their experience in sexual abuse cases. In their view, victims tended to be realistic (64%) in terms of what an officer can do during an investigation. Parents, on the other hand, were somewhat less realistic (42%) in terms of an officer's ability to do things. Social workers, according to the officers, were realistic (88%) in terms of what they could do, as were prosecutors (93%), and supervisors (97%) in cases of child sexual abuse. In terms of the community, 62% of the officers felt that their expectations were somewhat unrealistic in terms of what is feasible for an officer to do in a case of child sexual abuse.

The difficulties obviously arise from different understanding of the criminal code, offender's rights, and a victim's or family's rights in child sexual abuse cases. Obviously, more communication and understanding should occur between them in terms of what officers can and cannot do in these situations.

VII.3h ANALYSIS OF SKILLS AND KNOWLEDGE

In terms of overall adequacy or inadequacy of skills, 20% of the officers felt their skills and knowledge were very or quite adequate in ten or more areas, 23% of the officers felt they were very or quite adequate in five to nine areas, and 50% felt their skills were quite or very adequate in four or less areas. Most officers indicated that their skills areas in child sexual abuse cases were somewhat adequate or less than adequate.

In areas where they felt they had somewhat adequate skills or knowledge, 42% of the officers had checked five or fewer areas, 46% in six to ten areas, and the remaining 12% in eleven to sixteen of the areas described.

In the sense of inadequacy, 36% of the respondents didn't mention an area of inadequacy and 82% of the officers did not mention an area in which they felt very inadequate. Seventy-seven percent (77%) felt inadequate in one to five areas, 23% in six to fourteen areas.

As we review the table of skill areas, we find the major areas of inadequacy appear in interview aids (i), non-leading interview techniques (j) (which is very important in court evidence), understanding the response of young children (k). The other major areas are those directly related to abuse behavior of victims (l), physical indicators (m), and family dynamics (n) which are directly related to investigations and the collection of evidence.

As we review areas in which officers feel somewhat adequate, in other words, there is some need for the improvement of their skills and knowledge, on the average one-third to one-half of the officers checked every area listed. They rate their overall skill levels with children to be basically somewhat adequate or inadequate in 58% of the cases. However, when those skills must be extended to children who have been sexually abused, 72% feel somewhat adequate or inadequate.

What is of critical concern to the needs assessment is the distribution of the skill and knowledge between officers and their location. When examining the areas involving skills with children - interviewing, these skills tend to be concentrated, as one would expect in corporals, sergeants, etc. Approximately 25% of the constables, however, rated their skills as quite or very adequate. Some of the inadequacies in these areas come from both young and middle-aged officers. Even some female officers (66%) felt their skills were somewhat adequate or inadequate.

As one would expect, the more experience they had as principal investigators, the higher they rated their skills with children in interviews and in collecting evidence. However, what appears critical is that the more experience an officer has in cases - assisting on or as principal investigators - the greater the tendency they have to rate their skills as somewhat adequate and a few areas as quite adequate. Also, the more charges they have laid, the more they tend to rate their skills as quite adequate, rather than very adequate.

In handling children's fears during an investigation, the higher levels of adequacy were associated with urban areas, although several officers in rural areas felt their skills were sufficiently adequate. Somewhat adequate and inadequate in this area was near equal in urban departments or detachments but slightly higher in rural areas. Older officers (42%) more so than young officers (25%) felt sufficiently adequate. High levels of adequacy in this area was found primarily in officers who had been the principal investigator most frequently (ten or more cases in the past year). This relationship also held true for assisting in investigations (six or more in the past few years). This relationship held in terms of the building of rapport with children.

A similar pattern appeared in several areas - the validity of statements, adequacy of interviews, the need to tell the truth and purpose. Officers with the most experience, who were essentially concentrated in urban areas, as principal investigators and the laying of charges felt the most adequate.

In areas such as the use of interview aids, non-leading techniques with children, and understanding the nature of their response, only 24% to 33% of the officers felt sufficiently adequate. The inadequacy and somewhat adequate rating was distributed fairly evenly between all departments. Younger officers felt insufficiently skilled in these areas more so than older respondents. It is interesting to note that some officers who had done a few cases (five to ten) indicated the lower levels of adequacy (somewhat adequate and inadequate). Likewise, younger officers had less adequacy in non-leading interviews.

What appears to be occurring in these last skill areas is that most highly experienced officers (frequent principal investigators, most charges laid and assists) rate their skills as the most adequate, as do officers with the least experience. Those who have done a few child sexual abuse investigations tend to rate themselves as somewhat adequate or inadequate in these areas.

As we move to areas directly connected to child sexual abuse, approximately 13% of the officers consider themselves quite or very adequate in recognizing indicators and understanding the dynamics of sexual abuse. This finding was not associated with rank, but was with department or detachment - specifically Charlottetown and Summerside and those officers most highly experienced. We should note, however, that even the most highly experienced officers felt only somewhat adequate in these areas and this became more pronounced with officers with some experience.

What is significant at this stage of the needs assessment, is that a select number of officers are highly skilled and experienced in areas involving children who have been abused. Second, many officers have indicated their levels of adequacy or inadequacy in specific areas, many of which are related to the interviewing of children and the specific handling of child sexual abuse investigations.

What is of major concern to the needs assessment is the distribution of skills and knowledge and its depth. There are officers with moderate levels of skills and experience, in both rural and urban areas. The question is one of availability and access. What happens to cases, and hence victims and families, when this scarce resource is not available, or there is not quick access in a rural area - due to caseloads, transfers, vacations, sickness and in-service training among other things?

VII.3i PROSECUTION

The relationship between law enforcement officers and the Prosecutor's Office is critical in sexual abuse cases because of the nature of their interdependent relationship in terms of evidence, how it is collected and the expectations of each on their roles. Officers were asked what types of difficulties they experienced with prosecutors.

Among the major difficulties was availability of prosecutors, given their high case loads. When we combine that with the case loads of officers, who in some cases may be investigating forty to fifty cases, the scheduling of time for the discussion of cases and charges may become very difficult. To some extent, a number of officers felt their experience and training had created some difficulties with prosecution. This becomes even more problematic when a prosecutor has a low to moderate level of experience and training in the prosecution of sexual abuse cases involving children.

Some officers felt that the changing of prosecutors in cases, at times caused difficulties and delays in cases of sexual abuse. In addition, several felt there was at times pressure on the victim or victims during the prosecution phase.

Evidence, as would be expected, is a major difficulty to some officers both in terms of obtaining it and the expectations on the nature and sufficiency of that evidence for prosecution. It was felt by some officers that prosecutors may not fully understand the difficulties of collecting evidence, especially from young children. Some officers felt there should be more prosecutors with a higher level of specialization in child sexual abuse cases. That is, prosecutors who understand the collection of evidence in problematic situations and experienced in the difficulties of prosecutions involving the testimony of children who have been abused.

VII.3j PROBLEM AREAS

Officers were very candid about their frustrations in the investigation of child sexual abuse cases. They ranged from collecting evidence from young children, to some of their own inadequacies, to the sentencing of convicted offenders. The most problematic aspect of evidence was, as mentioned, young children - under four or five years old. The difficulty of getting a statement or positive tape interview was mentioned frequently.

The problem of collecting evidence becomes compounded by the fact that there may only be minimal evidence and victims or families can become uncooperative at this stage - even coaching of a child was mentioned several times as well as spouses defending the abuser.

Officers felt that if they had more time available they could devote the needed time to these cases. This was mentioned often by respondents. They also felt the needed time would be better spent if they had a better understanding of the psychological problems that victims experience. This obviously affects how an investigation proceeds.

Parents who obviously will be upset by the abuses, whether it is extra-familial or intra-familial, have expectations on officers as they conduct their investigation and how they deal with the offender. Some officers mentioned the frustration of trying to help victims and families, but still limit their actions and involvement because of the legal rights of offenders, the requirements of evidence for successful prosecution, and job requirement.

Coordination appeared as a frustration mentioned by some officers. The concerns were the investigations with Social Services, the role of Victim Services, the Prosecutors Office, even hospital staff. Likewise, communication was mentioned a number of times.

Several officers mentioned that at times victims or families will delay in reporting the abuse. This, for officers, creates difficulties in collecting evidence. This also, as would be expected, influences the ability of officers to lay charges and for the prosecution to proceed successfully.

Many officers also had comments about convicted offenders. They, like many others interviewed in this assessment, were concerned over the convictions, length of court, pleas and sentences of some offenders. Many officers obviously see these offenders on the "streets again" and investigate complaints which involve them in other abuse situations. Some officers in this sense also mentioned the effectiveness of parole and mandatory treatment for offenders.

Lastly, one of the more telling comments of officers concerned the nature of doing police work in rural areas. No matter how hard one does one's job or how concerned one is about the victim and their situation, "parents give you the cold shoulder" and "some people who are friends or relatives won't talk to you." This was coupled with statements that the public perceives the police as "doing nothing" about child sexual abuse.

More specific comments and recommendations will address these and other organizational issues in the later section on agency problems and needs.

Although 28% of the officers had some training in the interviewing of children, additional training for officers in terms of investigations concerning children and children who have been sexually abused was minimal - approximately 13% had reported any additional training in their education as law enforcement officers. Four officers had received additional experience in formal workshops on child sexual abuse. Seven officers, mostly corporals and sergeants, had received additional in-service training in interviewing children. This leaves the majority of officers, especially constables, with very little additional training from that received in formal training. Obviously this creates difficulties for officers, especially as they have rated their own levels of adequacy and inadequacies with children and especially those who have been sexually abused and the demand for sufficient evidence in cases which are difficult to prosecute and may have complex victim and family dynamics.

In summary at this point, there are definite needs for officers in both training and case experience, and especially in the laying of charges. Second, training and experience should reflect both rural and urban requirements for the availability of skilled and experienced officers. Last, training should be increasingly of a joint nature which reflects the mutual understanding of job requirements for both police officers and social workers while recognizing the dynamics of children and families who have been involved in sexual abuse.

VII.4 SOCIAL WORKERS

Social workers play two pivotal roles in child sexual abuse cases - investigating complaints and providing services to victims and families directly or indirectly through referrals. In the past year, interviews and discussions have been held with social workers to identify the needs they observe in both victims and families. Discussions and interviews also examined the difficulties and problems they experience in cases involving children in a personal way, as well as, in an organizational and inter-agency manner. Their perspective and attitudes towards child sexual abuse were also elicited.

Social workers and their supervisors have been very involved in a research instrument which was distributed to all workers and supervisors in the Department of Social Services. The instrument, which is more fully described in the section on research methodology, was designed to examine a number of concerns in depth. Their case experience with sexual abuse victims was examined. They also provided data about victims - namely risk levels, meeting their needs, contact with families and victims, roles they play, disclosure, risk levels, and the investigation of complaints. A great deal of data was also collected on their skills and training needs.

Sections included their experience with the problem of confidentiality, protocols, investigations with police, referrals, and different aspects of their interaction with other agencies (e.g., protocols, reporting, decision making and problems).

Other sections focused on what might be termed the "work and organizational needs" required for a more effective intervention and provision of the services delivered to children who have been sexually abused and their families. These areas included are caseloads, communication, supervision, procedures, accountability, case decision-making, determining risk, information flow, case planning, case conflict and, feedback among other things.

The final section included areas related to policy questions, mandates, inter-agency difficulties and a general attitudinal package toward sexual abuse, its causes and solutions. This data collection was designed to acquire an understanding of both the organizational and inter-organizational needs that must be addressed for effective intervention in cases of child sexual abuse.

The data from social workers was collected for two purposes one to identify and to measure needs at four levels - the victim and family, the work with clients, the organizational and work environment, and inter-organizational. Approximately thirty percent of this data was collected for the internal process of planning and developing an intervention model which could be adapted in Social Services and then integrated into Social Services relationships with other Service, Support and Justice agencies. It will not be reviewed.

Out of a working universe of forty-four workers, all received a research instrument. They included both social workers and supervisors. At the time of the writing of this report, forty-one had responded. Several will possibly respond later due to maternity leaves, sickness, etc. They will be included in the planning data for the intervention model. This creates a response rate of approximately ninety-four percent based upon a selection of the entire population of social workers in the Department of Social Services.

VII.4a BACKGROUND DATA

The workers who responded averaged a little more than eight years experience in case work. Thirty-eight percent (38%) had five or less years, 28% had six to ten years and the remaining 35% had eleven to nineteen years of case work experience. The distribution of years employed by the Department was similar with a slight tendency toward three years or less.

The respondents' education background included 14% with High School degrees, 7% community college, 52% with Bachelor's degrees (most were B.S.W.), and 28% had attained an M.S.W. The social workers' average age was 34 years of age and ranged from 22 to 60 years of age. Thirty-nine percent (39%) were under thirty years of age, and 39% were between thirty-one and forty. The remaining 18% of the respondents were between forty-one and sixty years of age. Eighty-three percent (83%) were females and 17% were male social workers.

The average caseload ranged between thirty-five to forty cases per month, with 20% with more than forty and 25% with fewer than thirty-five cases. The average number of services/month that they were responsible for averaged four with 35% between five and nine and 50% with three or less. On average, 15% of their caseload would involve children who have been sexually abused. The average is somewhat misleading, however, because 14% of the workers had between 16% and 25% of their caseload involve sexual abuse and 25% had between 26% and 40% or more cases of child sexual abuse. There was obviously a wide range of percentage caseloads involving sexual abuse.

In the past year, workers were asked to estimate the number of cases of child sexual abuse in which they had been involved. The average number of cases was approximately nine, the median (50% point) was seven. Forty percent (40%) of them had five or less, 31% had between six and ten and 18% had fifteen or more cases, ranging as high as forty. The reader should be cautioned in their interpretation of that data because more than one worker may be involved in a single case of abuse.

Workers' experience was primarily with females, with an average of five and one male. Some workers had extensive experience with females - 21% over ten females to as high as thirty-five. One supervisor had been involved in ninety complaints. Two workers had experience with fifteen and another thirty males. Obviously, worker levels and range of experience in sex-specific cases are disproportionately distributed.

VII.4b VICTIMS

A critical concept, although poorly defined, is the notion of risk level. It is a critical factor in case decisions. Also, it gives the needs assessment a sense of seventy cases that social workers encounter. It encompasses a wide range of factors which will be analyzed later in this review. They briefly include, severity of abuse, child's behavior, age, danger at home, among other things.

Social workers were asked on the basis of their experience in the past year what percentage of their cases of child sexual abuse would they consider as - high risk, moderate, or low or no risk. The following table present the percentages of each.

In their cases of children who have been sexually abused, social workers reported that an average of between thirty to forty percent of the children were to be at high levels of risk. Notice that the distribution is bimodal, a cluster of cases at 10-20% and another at 50 to 60%. This is associated with whether the social worker is involved in intake or long term. Moderate risk levels average around 30% of the cases they have been involved in and low risk would average around 25% of their cases.

TABLE 7.5

Percentage of Victims at Different Risk Levels By
Percentage of Workers Reporting These Levels

Joint Percentage Distributions

	High Risk	Moderate Risk	Low or No Risk
None At	10%	17%	21%
10% "	14%	10%	24%
20% "	21%	14%	24%
30% "	7%	28%	7%
40% "	7%	14%	0%
50% "	21%	3%	10%
60% "	10%	14%	3%
70% "	10%	0%	10%

Note: For interpretation purposes - 10% of the respondents indicate that 70%, or more of their cases were at high rise and l0% indicate that none of their cases were high risk.

Although a crude estimate, the data indicates that probably at least a third of the cases in Social Services over the past year involved children who were at high risk levels and require a very effective and timely intervention. This is similar to findings in the past and present data schedules reviewed previously. At the same time, approximately one third of the cases were at a moderate risk level which, as well, requires an appropriate response from workers and others.

Social workers, because of their contact with victims, especially over the long-term are in position to make a judgment of how well the "system" has met the psychological and social needs of their clients. The "system" includes, along with Social Services, the Justice System, Therapy and Support Services. The reader should be cautioned that workers have interacted with children at varying risk levels.

The average response of workers was a tendency to say the system responded inadequately. Sixty-two percent (62%) of them responded in this manner. Fourteen percent (14%) indicated somewhat adequately, and 24% judged that it was slightly adequate. On the other hand, of the 62% of workers who felt the "system" had inadequately responded, only 7% indicated that it was slightly inadequate. Thirty-one percent (31%) felt that it was somewhat inadequate and 24% felt that it had responded very inadequately to both in a psychological and social nature.

The same question was asked of workers in terms of families involved in sexual abuse cases. "After they (families) have experienced the 'system,' how well has it met their needs?" Workers, again, felt that the system had inadequately met their needs (69%). Thirty-one percent (31%) felt it had been adequate, but most said slightly. Fifty-eight percent (58%) indicated that it was a somewhat or very inadequate response to their needs.

Social workers communicate with victims and families frequently during the course of a case of child sexual abuse. The needs assessment was concerned with the nature of that contact. In other words, what did victims and families tend to require when they contacted Social workers? Workers were asked, how frequently do victims contact them for the following items. Their responses (in percentages) are identical to the percentage response framework used in the question.

The table on the nature of victim contact clearly indicates that nearly 40% of the victims frequently require information on a wide variety of matters. Likewise, the same percentage or more (41% to 44%) frequently require advice and direction in addition to emotional support. What is of particular interest is that 25% of the victims require advocacy frequently and 55% sometimes. What should also be stressed is that 70% of the contact of victims has any combination of these purposes of contact.

TABLE 7.6
Nature of Contact with Victims

	Never	Very Seldom	Sometime	A Lot	Quite A Bit	Always
A. Information	21%	14%	28%	24%	14%	0%
B. Advice/Direction	14%	14%	28%	17%	24%	0%
C. Emotional Support	14%	14%	28%	17%	24%	3%
D. Advocacy*	14%	7%	55%	10%	14%	0%

*Advocacy was in terms of talking or contacting other people on their behalf.

Nature of Contact with Families*

	Never	Very Seldom	Sometime	A Lot	Quite A Bit	Always
A. Information	7%	10%	31%	17%	31%	3%
B. Advice/Direction	3%	14%	31%	14%	28%	0%
C. Emotional Support	3%	14%	35%	10%	28%	7%
D. Advocacy	3%	14%	31%	28%	10%	3%

*Percentages will not total 100% on each item because one or two respondents did not answer the item.

In terms of families, at least 80% of the contact requires any combination of these purposes. Of particular note is that more than half of these contacts are frequent from families needing information, advice and support. In addition, families are making contact (41%) frequently for some type of advocacy.

To get a better perspective on the need for advocacy, workers were asked how often they actually find themselves acting in an advocacy role for victims - talking to people or agencies on their behalf. Not a single worker said they never find themselves in that role and one worker said seldom. Forty-one percent (41%) said sometimes, 24% said a lot, another 24% said quite a bit and 3% said they were always in that role with victims.

Workers found themselves actually in this role a little less frequently for families. Ten percent (10%) indicated seldom, 52% sometimes, 24% a lot, and 10% indicated quite a bit or always. In general, social workers find themselves acting in this role frequently for victims and families (27% to 34%).

To determine whether or not there were victim or family needs after a case, social workers were asked how frequently they have contacts following the formal closure of a case in the areas of information, advice, support and advocacy from victims and families. About 10% said never, 24% seldom, 52% sometimes and 7% quite often. Seven percent (7%) did not answer. The responses tend to indicate there is need, and it may be moderately frequent among victims and families.

In addition to need and meeting of need through responses by the system, our concern in the assessment was the number of cases that after the intervention by the system still had very negative outcomes. Social workers were asked this question in terms of their recent case experience. What percentage eventually have very negative outcomes? The following distribution provides the range of response by social workers.

Percent of Cases With Very Negative Outcomes	Percent of Social Workers Estimating That Level of Negative Outcome
10%	11%
20%	15%
30%	31%
40%	8%
50%	15%
60%	8%
70%	14%

The median response (50% point) is around thirty percent (30%). However, our mean response would be closer to 40% with very negative outcomes when our standard deviation is about 20% on either side of that percentage distribution of negative outcomes. This suggests to us that our range of estimated negative outcomes is wide and despite the nature of the intervention by the system, at present, 30% to 40% of the victims and families do not do well after their experience in an intervention. The model of intervention obviously must take great effort in revising all the individual actions of the system in response to victims to decrease these percentages.

Cases of child sexual abuse vary in terms of their severity and the required response to the child and family. Responses are most significant when the child or family is at high risk. Consequently, social workers were asked, "... in the past year, how many of your cases required an emergency-type response" or a "crisis type intervention" before the case was validated? They responded in terms of absolute number of cases. Workers reporting none 35%, one 14%, two 21%, three 0%, four 7%, five 3%, six 3%, seven 7%, and eight or more 10%. The numerical average of crisis types of interventions is each worker had at least two to three crisis-type cases last year. A computed total of cases would suggest 73 cases required emergency response. We must note, however, that several workers may have responded to the crisis. Based on other figures, the most appropriate estimate would be about forty to fifty. What is important to recognize at this point, is that emergency or crisis response does not only occur before validation of a complaint. It occurs after, as well. Workers were asked, how many cases in the past year required an emergency or crisis response after validation. They responded in absolute numbers of cases. Forty-four percent (44%) said none, one case 17%, two cases 10%, three cases 10%, five cases 7%, eight or more cases 10%. Numerically, each worker was indicating about two cases/worker, nearly 30% were reporting four or more. The more appropriate estimate would be about twenty-eight cases based upon the survey responses. A corrected estimate based upon response totals would be forty cases.

We should note that emergency or crisis-situation usually do not only require a social work response, but a coordinated response from a number of other agencies and support facilities.

Victims experience a variety of occurrences during an intervention. Some of these are very difficult to measure. However, social workers have an opportunity to observe how frequently situations occur for victims and themselves in making case decisions. Workers were presented with a variety of situations and asked how frequently these situations had occurred for victims or themselves while in the "system." Please note that both intake and long term workers are responding to these questions. Hence they would have somewhat different experiences. In addition, some workers have vastly more CSA case experiences.

The following table gives us a better sense of how frequently certain situations may appear for victims and social workers. We immediately recognize that workers may feel that delays in therapy occur frequently for victims. Likewise, court and court delays, tend to have a negative impact when the delays are too long. What is striking, however, is that some of the workers report that victims may be abused again. It may be a lower frequency, but it occurs. Lastly, there are a moderate number of victims and families who return to Social Services. There are a number of frequent situations that happen to victims that create additional needs for victims which the intervention model must address through an inter-agency response that is planned and coordinated.

TABLE 7.7
Frequency of Case Situations*

	Never	Very Few Times	Sometimes	Quite a Few Times
a. Charges but no prosecution	48%	21%	17%	11%
b. Sufficient evidence for child protection, but no charges	35%	21%	31%	10%
c. Delays in access to therapy	10%	10%	21%	48%
d. Therapy did not help	7%	10%	41%	31%
e. Prosecution or court delays were too long	10%	3%	34%	41%
f. Negative impact by court	7%	17%	52%	14%
g. Case ended up in Social Services again	7%	14%	38%	35%
h. Child was abused again	35%	35%	21%	5%
i. Perpetrator was a young offender	24%	17%	41%	7%

*Percentages may not total to 100% because one or two respondents did not respond to a particular item.

VII.4c DISCLOSURE

As past research and the current needs assessment have demonstrated, disclosure by a child that they have been sexually abused can cause varying difficulties for the victims, their families (in both intra-familial and extra-familial cases), and for the workers investigating the complaint.

Research on disclosure is very sparse. Cases of the sexual abuse of a child may be based upon what may be termed "accidental" or "purposeful" disclosures. Purposeful is obviously deliberate. On the other hand, accidental is considered not to be a deliberate effort. However, what is not deliberate is difficult to determine. In any case, accidental disclosures may occur in sexualized behavior - something shared with a friend, etc. Accidental typically involves a second party who then may or may not report the "disclosure."

When we asked workers how frequently in their case experiences had accidental disclosures occurred ("what percentage of your investigations have been based upon accidental disclosures") they gave the following responses. Please note that some of the respondents are long-term workers who may have fewer complaint investigations than intake workers. Fourteen percent (14%) said it happened in 10%

or less of their cases, 21% indicated in about 20% of their cases, 14% said in about 30%, 21% said in about 40% of their cases, ten percent said in about 50%, and 24% reported that in more than sixty percent (60%) their investigations were based upon accidental disclosures. A crude average would indicate 40% of their cases are based on accidental disclosure. This implies that many children who are victims will be or have to be confronted with the possible abuse. In addition, if accidental disclosures are not responded to by a second party - a mother, friend, teacher or relative, the abuse may never be reported or it may take considerable time, as our other data indicates, before it becomes known to those who can respond. It may never become known until the victim is an adult. As noted elsewhere, in Mental Health Services there were one hundred and eighteen referrals opened for adult survivors in a one year period from 1989 to 1990.

We were also interested in the speed and comprehensiveness of disclosure. Other data of this nature was collected in the data schedules. We asked social workers about their experience in disclosure, especially how frequently do they obtain a full disclosure in the initial interview with a child. This data is obviously influenced by case experience with young rather than older children, and whether or not they are intake workers. In any sense, it gives us a general estimate of speed and comprehensiveness. Social workers were asked to respond in percentages of their cases where a full disclosure occurred in the first interview.

Twenty-eight percent (28%) said in 10% or less of their cases, 17% said in about 20% to 30% of their cases, 28% said full disclosure occurred in an initial interview in about 40% to 60% of their cases, and 21% indicated in 70% or more.

Obviously these results are influenced by number of cases and investigation skill/experience. It indicates to us that many cases obviously require multiple interviews. Other findings in the assessment indicate that as the number of interviews increases, the probability of victimization also increases. In terms of prosecution, it also means the nature and utility of evidence for prosecution will decrease as we move to multiple interviews. It also points out the requirement for effective and cooperative investigations by social workers and police. They must obviously be highly skilled and sensitive.

Victimization for the child and case difficulties increase as does denial or, more importantly, recanting by the child of the allegation of sexual abuse. Figures on denial are very inconclusive, however, since the needs of victims and the nature of investigation are major components of the assessment. Workers were asked about their experience with both. The data from workers indicates that denial occurs frequently. Twenty-four percent (24%) said it happened in 10% or fewer of their cases, 40% in 20% of their cases, 20% in 30% to 40% percent, and 7% in about half their cases.

Denial is a complex phenomena. It can be the result of a false allegation, the nature of the investigation, fear, pressure from the offender or family as our data already indicates and hence, can result in major difficulties for the child. Likewise, the decision-making in cases by social workers and police becomes more complex and requires even more skill and sensitivity. What becomes significant to the needs assessment is the effects on the victim due to length and its influence on evidence and case decisions, and more than likely upon the family. The data from several sources, especially this one, indicates that it is a frequent phenomena and must be responded to in an intervention model by both plan and skill of social workers and police officers.

Recanting part or all of a purposeful disclosure, especially at the point it occurs during the process of intervention, may be the result of "extreme pressures" on the victim or what the victim is experiencing. The complexities created for those who respond in the situations are numerous and discussed elsewhere - the nature of the current intervention will have to dramatically change. Most workers report that it has not occurred very frequently but on average it occurred in 10% to 20% of their cases. Some, especially intake workers, report slightly higher percentages. On average, 30% of their cases involved some form of recanting. This entire process, its causes and control, are significant matters for the intervention model. Its frequency may be somewhat less than other phenomena, but its effects are very significant upon a victim and all those involved in an intervention.

Some children, despite the denial or recanting, may reaffirm an allegation or previous disclosure. Our interest was directed toward how frequently social workers experienced this occurrence. The question was how many never reaffirm or continue to deny? Workers, in general, said basically some cases never reaffirm or continue to deny. It would be difficult to estimate exact numbers. Based on our other data on validation, however, we may say that 20% to 25% continue, once they have denied or recanted.

Although it is difficult for one to really know why a child may deny, recant or fail to provide sufficient detail about alleged abuse, we asked workers to review their experience in these cases and provide us with a sense of what "caused" the denial or recanting by the victim. The following table presents the findings from the workers on these "causes."

The data immediately indicates that a victim will deny or recant for a variety of reasons, and secondly, they are complex combinations depending upon the nature of the situation. What is of particular importance to us in these findings is that other victims experience the same feelings or pressure, and they do not deny or recant. It is important for the model of intervention to address this issue and address the dynamics of what a victim is experiencing before they decide to deny or recant - what can intervenors do in these frequent situations, what can they modify in the process of investigations?

TABLE 7.8
Causes of Denial or Recanting

Cause	Never	Once in a While	Some-Times	Half the Time	Often	Very Often
	Frequency of Occurrence in %					
a. pressure from the offender	4%	22%	13%	34%	9%	17%
b. pressure from the family	0%	12%	31%	15%	27%	15%
c. fear of being separated from the family	0%	4%	16%	8%	40%	32%
d. other people will know	12%	24%	28%	0%	20%	16%
e. fear of court outcomes for the offender	8%	16%	28%	16%	20%	12%
f. fear of breakup of the family	4%	0%	20%	20%	24%	32%
g. nature of the investigation	7%	24%	40%	12%	0%	12%
h. guilt or the feeling they'll be alright on their own	13%	21%	25%	21%	17%	4%

As our other data indicates (Case Problems Index) offenders exert pressure on victims and it appears to frequently work for the offender. Likewise, the family has a fair degree of influence upon the victim in not only intra-familial abuse but extra-familial abuse. By and large, the fear of being separated from the family or its breakup is a very major reason for denial or recanting. It is interesting to note that the typical assumption for denial or recanting is the publicity or "others will know." In rural areas, they probably already do. What is interesting is that workers see this as less of a reason for the victim acting in this fashion or deciding to recant than others. The item should have been divided into sub-questions about both denial and recanting - this probably explains the bi-modal distribution, as would a rural and urban split.

Lastly, one issue seems significant for some victims - what will happen to the offender? Workers are reporting that around half the time it is a reason for denial or recanting. It would seem apparent that the victim requires an early intervention of therapeutic counselling or support to deal with this issue and resultant emotions and feelings. Likewise, in situations when victims experience guilt or they feel they can handle the situation on their own. We see this occurring in some to half of the cases. Immediate counselling should probably be available to these victims.

The concern of the needs assessment cannot only reflect the needs of those who "put up" with the system and never deny or recant, it must also ask what happens to those children who deny or recant. Are their needs responded to? Do they have access to support, treatment and healing on an equal or less than equal basis than other victims? What are the long term consequences of cases where the intervention process has failed? What are the real costs to the Mental Health and Social Services system, even Justice after denial or recanting occur?

Social workers made some very interesting comments on the issue of disclosure and denial. From experience, some felt that you have to "wait," the disclosure will come. This raises an important issue with regard to the demand by others for social workers or even the police to get the disclosure and evidence as soon as possible to satisfy their mandates. This may be an area which requires considerable policy discussion based upon experience and the needs of victims.

VII.4d YOUNG OFFENDERS AND SOCIAL SERVICES

Although Social Services responds to victims, they become aware of and "respond" to with young offenders (under 18 years of age). These offenders, as research points out, also continue to abuse as adults. In the past few years, workers have seen, on the average, three to four each, nearly 25% had seen six or more in the system. Half were between eleven and thirteen. The other half were between fourteen and seventeen. Fourteen of the workers said Protection Files were opened on those offenders which would be approximately thirty to forty over the past two years. Approximately 70% of the workers felt there were insufficient therapeutic services available for these cases of young offenders. The primary concern among workers was that these offenders may fall through "cracks in the system" due to mandates and ultimate responsibility for young offenders.

VII.4e SOCIAL WORKERS - JOB NEEDS

There are numerous areas where social workers need assistance in their casework. Journals in many disciplines have described their needs and have suggested solutions. Our concern is specifically with needs connected to their interaction with victims and their families. Other parts of our research examine organizational variables connected to structure, policy and inter-organizational variables which are examined later.

VII.4f CONFIDENTIALITY

Confidentiality is frequently seen as a major difficulty in the investigation and delivery of services to children and families. Social workers were asked how frequently it was a problem in the investigation of allegations. About half the respondents said seldom (52%), 17% said sometimes and 25% said quite often or most of the time. The difficulty is that when it is a problem, it may turn into a major problem affecting an investigation, especially one based upon allegations. Methods and policies, obviously, have to be devised to deal with those situations.

In terms of service delivery to victims and families, 55% of the social workers said it was never or seldom a problem, 31% said sometimes, and 11% said frequently. The challenge to the intervention model is that workers require means to deliver services when confidentiality becomes a problem. This occurs sometimes. Ensuring that every victim and family have equal access and delivery of services despite the problematic nature of the situation is important.

By and large, confidentiality significantly influences the reporting of incidents of abuse, despite mandatory reporting requirements, by other agencies and the public. Thirty-one percent (31%) of the workers said it is seldom to never a problem - mostly seldom, 31% said it is sometimes a problem, and 31% said it was frequently a problem. If it is moderately frequent, the investigation may be restricted or the time of response delayed. The percentage varies some on the basis of a worker being an intake or long term worker. Victims, therefore, are subject to the cooperation of the person or agency who report a complaint. A major system need, then, is to address confidentiality as an issue to enhance the response to victims, and provide social workers with consistent and effective policies for these situations.

VII.4g REPORTING

As we discuss reporting, it is important to note that numerous agencies and the public are required by law to report abuse. Workers in both interviews and discussions felt reporting was a major problem in sexual abuse investigations. Workers were asked how frequently agencies had followed mandatory reporting requirements. In general, most agencies were not frequently following them. If they were, it might be consistently, which becomes a problem. Sixty percent (60%) of the workers questioned, said sometimes or less. Schools tended to more frequently follow them. Police most frequently followed them. However, both were also only following them sometimes or less (20%). Therapists were basically following the requirements, however, again 30% of the workers indicated sometimes or less. This area has a major confidentiality issue that the intervention model must address. Community support groups were following the requirements, sometimes or less, according to 40% of the respondents. Volunteer organizations, were sometimes or less, according to 50%. Daycare agencies and church organizations were seen as a problem. The difficulty is understanding and knowledge of the requirements, plus confidentiality. Major efforts should be put into this difficulty and upon easing the nature and fear of reporting to Social Services.

VII.4h INFORMATION

Information connected to an allegation of sexual abuse can significantly affect the decision-making and flow of an investigation. We asked workers how much information, either verbal or written, do they usually have when they start an investigation. Thirty-five (35%) of the workers said very little, 55% said little or some, but not enough, and only 20% said enough. Despite amount, accuracy of the information is important. Thirty-five percent (35%) of the respondents indicated that there was some accuracy, but not enough. About 50% said enough and 10% said a great deal.

Clearly in terms of the amount of information, it should be increased during the reporting process, even though difficult, as should accuracy. Although, hearsay allegations, however, limit these possibilities.

Social Workers, as workers in other fields, must respond to allegations of sexual abuse. At the same time, like other professionals in therapy, justice, etc., workers may not feel comfortable in doing child sexual abuse work. That was our initial assumption, given the lack of research in this area. When asked,* as were police, how comfortable they were with this type of work, no worker responded that they were never comfortable. However, there was a range of comfortableness with sexual abuse cases. Twenty-eight percent (28%) felt they were hardly ever comfortable, 24% were comfortable some of the time, 34% were comfortable most of the time, and 14% were comfortable all of the time.

Social workers were quite explicit when giving their reasons for feeling uneasy. Some identified the fact that sexual abuse cases usually have numerous other problems. As we mentioned before, there is a moderate percentage of multi-problem families involved in these cases, and both victim and family have to be responded to. If workers have several over a long period of time, they feel they can become overwhelmed by those problems. Other workers felt that more training would help, as did police officers. More will be discussed on this later.

Some workers indicated that everyone involved becomes victimized as the case moves toward criminal prosecution and it becomes depressing. Complexity was felt to be a reason at times. Difficult cases become very complex with highly charged emotions on the part of everyone involved, especially the victim. Some workers felt apprehensive when there was violence involved and it was incestuous.

Several workers highlighted the matter of denial by both the victim and the family. In these situations, the intervention becomes difficult and problematic. Although many felt this was part of what social work was "all about" and these children required an intervention. In addition, comments were made that it was hard to be non-judgmental. Some workers felt they had a true acceptance of the child's need to be protected and also deny the abuse happened. Some mentioned that children had rights too, so they tried to stay comfortable with cases of sexual abuse.

Some workers felt that the more experience and training they had, the more comfortable they were with victims. Some felt that experience, as one stated it, makes you "shock proof." Ease of dealing with cases of sexual abuse was also a function of peer support. The more you had, the more comfortable you felt. That was a very frequent comment.

Several factors appeared when comparing those workers who were comfortable a lot of the time, most of the time or always, with those who were comfortable sometimes or hardly ever. Peer support, supervisory support, experience, and training seemed to be associated with ease of involvement in cases where children had been sexually abused. The need to intervene and being comfortable with your own sexuality were also mentioned by workers who were at more ease with cases. It was interesting to note that several comments were made to the effect that if they had difficulties with a case, they had others they could get help from quickly.

Obviously, as conditions of a work environment and training for social workers, these issues have to be addressed in a redefined intervention model for both Social Services and other agencies. More will be discussed on these topics in following sections.

VII.4i WORK SKILLS AND PAST TRAINING

Work skills obviously influence how one does casework, as does experience and the other factors mentioned in the previous section. A large inventory of skills was identified to workers which, according to past research, are part of effective interventions, especially at the early stages of sexual abuse cases involving children. In short, workers were asked to rate themselves in sixteen different areas. The focus of this part of the instrument was to identify areas where training should be increased for social workers dealing with sexual abuse cases of children.

Social workers were first asked, "have you had enough training and experience to deal with all the cases that were assigned to you"? Forty-six percent (46%) said yes; 54% said no. At this point, we should note to the reader that case assignment of social workers to sexual abuse cases is not random. It is a function of a number of factors - supervisors, caseloads, experience, and case demand among other things.

Obviously the above statement requires clarification for our determination of training and experience needs. Workers were asked, "what percentage of your cases did you really feel you had enough skills and experience to handle those cases effectively"? Seven percent (7%) said yes for between 0-20% of their cases, 22% for between 21% to 40% of their cases, 14% for between 41% to 60%, 33% indicated they had enough skill and experience for 61% to 80% of their cases, and 22% felt they had sufficient skill and experience in 80% or more of their cases. In general, social workers felt they had enough skill and experience for many, but not all, cases of child sexual abuse assigned to them. We should caution the reader that when we control for case experience, the level of 61% and above is from social workers with moderate to extensive experience in the past two years.

It is interesting to note that 62% of the workers had some or no training from formal sources - university, etc. Most of their skill comes from on the job or in-service training. In any case, workers identified what they felt were areas in which they required more training and expertise. Ninety percent (90%) of the respondents felt their skills in recognizing the signs or indicators of sexual abuse were good to excellent. About 18% felt their skills in collecting evidence in terms of the CFS Act were fair or less. Workers ranged widely in their skills in terms of the Criminal Act. Forty-three percent (43%) felt their skills were fair or less, 39% felt they were good and 17% felt they were very good to excellent.

In terms of interviewing children, about 41% felt their skills were fair, 21% good, and 38% very good to excellent. About 30% felt those skills were fair in terms of families. Most felt these skills were good in utilizing their authority. Only 18% felt their skills were fair in assessing a child's behavioral or emotional status. Almost all workers felt their skills in assessing parental capacity and parent-child relationships were good to excellent.

When social workers were asked about assessing the child's needs, 63% felt they were good and 37% said they were very good. No respondent said their skills were excellent. In assessing parental protective response, 5% said good and 42% indicated very good and 7% excellent. fifty-four (54%) indicated fair.

When workers were asked about assessing the offender's response to the situation, quite a variation in responses appeared. This item is important because it may significantly affect an investigation and estimation of risk to the child and family. In the same sense, it may cause "over-reaction." Eight percent (8%) said they felt their skills were poor, 32% said fair, 28% said good, and 28% indicated good to excellent.

Coordinating skills are important to a social worker in all casework, but especially in child sexual abuse cases where services require arrangement within and outside an agency. Within Social Services, they felt their skills were good to very good. Outside of social services, 4% said poor, 18% fair, 43% good, 32% very good, and 4% excellent. In and of itself, these percentages may be fine. However, within a needs assessment, cases of sexual abuse may require higher levels of coordination than usual. Sixty-five percent (65%) of the workers reporting good or less skill may be insufficient to meet the needs of victims and families, especially multi-problem and difficult cases. More will be said on this topic later.

VII.4j PERSONAL SAFETY

Workers at times may become concerned about their own personal safety in cases involving sexual abuse due to threats from offenders or others committed to the case. Workers were asked if this had happened to them in the past few years. Sixty-six percent (66%) of the workers indicated that it had not happened, 17% reported that it had happened once or twice, and 14% said three or more times. For one worker it was quite frequently.

At times, social workers in these cases are not threatened verbally, but may feel threatened. Twenty-eight percent (28%) indicated that it had not happened in the past two years. Forty-one percent (41%) said seldom, 24% sometimes, and 4% numerous times. The probability of threats increases as case numbers increase. Workers indicated that they (35%) were a little or somewhat more concerned in sexual abuse cases. This is usually coupled with the high emotions that surround such cases. Some workers (17%) were concerned about the amount of support they receive from their supervisors and 14% were concerned about the amount of support they receive from the police.

When asked the direct question "does your concern for your personal safety affect how you handle a case of sexual abuse?", 38% of the respondents said yes. Most felt it affected the involvement in the case some.

As an issue, social worker safety will have to be addressed by agencies in some cases if it directly affects how a case is handled or the nature of an intervention for a victim.

VII.4k WORK FRUSTRATION

Professionals in many areas of human services frequently feel frustrated by their attempts to intervene and the outcomes they observe. Some of those difficulties are connected to work and others to clients. Frequently, social workers attempt to monitor their clients and attempt to intercept or avoid potential problems and difficulties in a proactive fashion, especially in cases of child sexual abuse.

When asked if they can usually effectively monitor their clients, many said "no" (48%). Of those that indicated they could, 61% said only very little or some of the time. Likewise, many felt that their follow-up case plans with victims were not completed. Seventy percent (70%) felt only half or fewer case plans were actually completed with victims or families in child sexual abuse cases.

Social workers can often feel frustrated by what they felt was in the best interests of the victim or family and what they wanted to do versus what they could actually do given a variety of constraints, both systemic and client related. Forty-five percent (45%) of the respondents felt this some of the time and the remaining 55% felt it frequently.

Some of that frustration involves what the victim and family will actually allow the social worker to do. This also involves their cooperation. When asked how frequently they were frustrated by that, about 28% reported it was seldom, 50% sometimes, and 18% felt they were frequently frustrated. This is a common dilemma in human services, but seems to be heightened in sexual abuse cases because of the size and nature of the interventions that are frequently required.

The other component of that frustration is obviously systemic - regulations, directives, and policies. Workers felt to a varying degree that they had flexibility in the "rules" for service and service delivery. Twenty-nine percent (29%) felt they had no difficulty with flexibility, 22% a little, 28% felt they had some. Only 14% indicated they had a lot of difficulty or it was impossible to bend the rules.

Although many of these frustrations are present in human services, according to our findings, they seem to be heightened in sexual abuse cases. Despite the fact that there is some flexibility in the rules, cooperativeness and willingness to participate in the intervention seem to be very problematic. What is apparent at this time is the need to have the victims' and families' goals integrated into intervention and services, thereby increasing their cooperativeness in a very complex and intrusive situation.

VII.4I ATTITUDES

The attitudes of social workers toward a number of areas related to interventions can influence the nature of case decisions in those interventions. They do not determine behavior, but have an influence in conjunction with other factors related to particular cases. Workers were asked their opinions on a large number of areas connected to decisions that are made in an intervention. The instrument contained twenty-nine opinion items. We have to thank them for their perseverance and candidness.

Since there is so much data in that part of the research instrument and it was obtained with guarantees of confidentiality, the needs assessment will focus on the nature of consistency or diversity of opinion rather than absolute percentages of agreement or disagreement. This information is most relevant for policy and structural decisions within the Department of Social Services. The response framework utilized in the questions involved six categories of agreement or disagreement whereby the respondent could state whether they somewhat, strongly, or very strongly held an opinion on an issue.

In general, workers were in agreement with the current philosophy of the Child Protection Act and felt it essentially reflected their beliefs and attitudes. This is important, especially in terms of protection issues. In terms of investigations, there were a number of issues presented to them. First, there were issues concerning investigations involving preschool children. Most strongly agreed that they be fully investigated. When sufficient evidence was present, however, there was some diversity of opinion on whether criminal charges should be laid. Most felt they should be laid. Others questioned if it always fit the best interests of the child.

In some cases of incest, there is a divided opinion about removing offenders in some jurisdictions. Here, most workers felt that it should be done, some agreed except for certain situations. All agreed that criminal prosecution should be pursued, but some indicated a degree of hesitancy.

In cases of sexual abuse, there are many diverse opinions about "rescuing" children immediately to prevent further abuse. There was a lot of diversity of opinion on the issue. Whether or not parents should have an input into the decision to proceed criminally has received much discussion, even in the Advisory Committee. In cases of intra-familial abuse, many workers felt that they should not. The majority tend to just slightly agree or disagree. Again, this is a very case specific decision and depends upon the complexity of the situation. In extra-familial cases, again there was a diversity of opinion on family input into criminal prosecution. Half agreed and the other half disagreed. The majority were just somewhat agreeing or disagreeing with the statement. These issues are connected to a much larger issue of what will best fit the needs of the child and the nature of police investigation and prosecution.

Workers tended to disagree over the issue that the mandate of the Child Protection Act should take precedence over the child's needs in a complaint interview. On the other hand, they tended to agree that the mandate should take precedence over a family's need in interviews connected to complaint investigations. In any case, most strongly agreed that every resource should be put into the validation of a complaint and an investigation of sexual abuse. In addition, most felt that legal intervention was required in cases of incest.

In terms of offenders, the majority felt young offenders should be charged. This had mixed reaction, however, with many tending to only somewhat agree and disagree. This may be connected to the issue of sexual abuse involving siblings and other similar situations with minor offenses.

With regard to therapy, most workers felt that children who have been abused needed therapy. A few somewhat agreed or disagreed with this issue. On the other hand, families involved in incest were seen as definitely needing therapy. There was some inconsistency in opinion, which is quite common in human services, about victims and families taking responsibility for most of their own needs, with a tendency to disagree in terms of victims and somewhat agree in terms of families. Lastly, there was diversity of opinion in terms of family reunification as a goal of case plans. Most agreed, and others were only somewhat in disagreement.

The transfer of cases from intake to long term was an external coordination issue raised in a previous section of this assessment. Most workers felt that the initial worker should have responsibility for a case of child sexual abuse until it is closed. There was a tendency, however, to somewhat agree and disagree on this question. Likewise, in terms of cases with long investigations, many workers felt that the initial worker should have main responsibility for the case, even if it is transferred. Those opinions were to some extent a function of whether or not the respondent was an intake or long term worker.

The role of a worker in cases of child sexual abuse sometimes requires constant monitoring or even trying to force an outcome. As in other areas of human services policy, there was much diversity of opinion on this issue. Lastly, the use of a generic model of services is a contentious issue. However, in cases of child sexual abuse, it becomes more so. Although respondents tended to disagree slightly, the trend was to only somewhat disagree or agree with the issue of generic services.

In general, there was a consistency of opinion in major issues connected to the mandate of the child protection and the criminal code. The diversity that remained appear to be a function of case specific situations. Issues connected to decisions concerning "rescuing" children were somewhat inconsistent, as were the responsibility of the client for meeting needs. Internal policy issues were somewhat consistent but generally influenced by the work of the respondent. More will be discussed on these findings and their relationship to decisions, in the section on Agencies Needs with other needs related to work and work environments.

VIII SERVICE AGENCIES

VIII.1 INTRODUCTION

The following section is divided into two major subsections - agency and inter-agency. As the report has previously stated, there are numerous agencies that affect the overall outcome for a victim of child sexual abuse and their families members. The needs assessment has identified a number of areas which should be addressed in an intervention model for children and families. Some are organizational specific. Others are inter-organizational and primarily coordination oriented. Some of the more detailed aspects will have to be dealt with in the planning phase. The Organizational or agency focus will concentrate on goal structures, structural changes, resource adaptations, process changes, specialization, policy, and several factors necessary for inter-organizational coordination and the development of a "network" of response to victims and families which is "coordinated" in process.

VIII.2 GENERAL STATEMENT OF FINDINGS

Information on agencies and inter-agency coordination was derived from numerous sources, some of which have been fully or partially reviewed. These include personnel interviews, discussions, meetings, Advisory Committee reviews, research instruments and personal observations.

In general, we find something referred to as a system, which is not a system in the true sense of the concept. Systems are comprised of components which are linked in an interdependent manner for a defined purpose or goal. To some extent we feel most agencies in the present system of response are operating independently within the confines of their own mandates and have, at best, a minimum level of "pooled" interdependence. That is they make decisions, they intervene, provide service or support to victims and families in a manner that is independent of their effect on other components in the "system." This has been found to be very characteristic of all the components in the system of response to children and families. It begins with the process of reporting by numerous agencies (schools, day care, etc.) who are required by law to report the sexual abuse of children to the police or Social Services. This lack of interdependent action continues through to actions by court, parole, probation, treatment, support and the monitoring of the child and the family. In the present "system," it is difficult to determine what is an effective "systemic" intervention. As therapists and social workers have told us, it is not difficult to determine what is ineffective - closely observe many of the client and family outcomes that have been reviewed throughout the report.

An outcome for a child who has been abused is the result of the functioning of staff in agencies, the agencies themselves and the nature of their inter-agency relationships. One goal in the previous section was to examine staff and their needs in relation to creating positive outcomes for victims. In this section, we examine organizational "needs." Agencies create the work environment, provide the resources, and create the constraints of stimuli through policy, structures, and processes in which staff must operate. In our review of the data, some of these agency needs have already been identified.

As we examine the goals of the agencies involved in this "system of response," there is one immediate finding. Each agency has quite separate goals, and these goals do not necessarily benefit nor involve the victim or family directly. In organizational terms, they are independent and sometimes contradictory goals with a low potential for overlap. In this present situation, the potential for an integrated approach toward coordination and "positive" outcomes for victims is significantly reduced. As we moved between agencies separately, we find a number of processes - protection, criminal charges, sentencing, support and treatment among other things. The question arose - to what degree were they integrated as a response to the victim and family? Observations indicated very little. If they were integrated, it is on an informal basis, case specific, and possibly only two or three of the above processes. This does not guarantee access nor quality of response to all victims and their families, even at the stage of just reporting sexual abuse to insure a timely response.

Our earlier research into this "system" of response indicated there was some, but a minimal degree of interdependence between workers, and very little between agencies. In other words, the amount of interdependence there actually is was "unrecognized" and presumed to be purely what we term pooled. Everyone did their small part to contribute to a "final" outcome for the victim, the family and the offender. The question of the nature of the outcome is presented later. What is apparent in this analysis is that the interdependence between agencies and workers is only minimally "pooled." It in reality is to some extent sequential and in most cases reciprocal in terms of outcomes for victims.

To briefly explain, the court is dependent upon the prosecutor and the prosecutor upon the police. They create a sequential product - evidence, charges, prosecution, trial, sentence, parole, and so forth. On the other hand, as we move between systems, like Social Services, Mental Health, Support Services, and Justice, one realizes that what the police do in an investigation affects what a social worker does and in turn affects what a police officer does and in turn what a therapist is confronted with. In another example, what a therapist does affects what a social worker does and what the court or victim services may do affects what a social worker or support worker must do. All of this is hopefully for the benefit of the child who has been sexually abused. In short, the "system" is reciprocal, but it is unrecognized and not integrated for the single purpose - the safety and healing of a child who has been the victim of sexual abuse.

Before a "new" systemic response is established presuming there is an old system, certain organizational features are required. An inter-organizational response coordinated for the victim's benefit can only then be constructed. At present, there seem to be too few pre-conditions necessary, both organizationally and inter-organizationally, for an integrated network of response. What is first required are changes within agencies, as well as, the development of a inter-agency network for an integrated approach and a level of cooperation to begin the establishment of a structure that shares resources, goals and a commitment to a positive outcome for the client.

ORGANIZATIONAL REQUIREMENTS

In this section we will try to deal with each agency who responds to children independently without specifically referring to an individual agency. At times, however, this will be hard to avoid. As we proceed through agencies, we will review work-related conditions and focus upon agency requirements.

VIII.3 LAW ENFORCEMENT AGENCIES

In terms of Police Departments, one of the major needs which has been recognized by both municipal officers and members of the RCMP, is training in the area of investigations involving children, especially those who have been abused. Another area of the report has identified the most important areas. Officer skills, knowledge and experience have been demonstrated to vary considerably in both municipal departments and RCMP detachments. The assessment has also indicated there is little formal training among law enforcement officers in areas related to investigations involving children, and sexual abuse.

Police officers seem to have varying degrees of "comfortableness" when conducting these types of investigations because of the nature of sexual abuse, family dynamics, and what may be termed difficult cases. Despite the ease one feels for these types of investigations, there is a need for, as one judge put it, "good evidence." This requires effective and timely investigations which may be very difficult in many cases with a sufficient degree of sensitivity to the victims and families needs.

As our assessment indicates, this comes with knowledge and experience.

Officers also require experience in interview aids and the effective use of video-taping. This is essential as courts increasingly permit the use of tapes in testimony. Investigative techniques will also require some degree of enhancement since the lack of cooperativeness may delay the collection and quality of evidence, especially from children. Supervision and evaluation will be required as these techniques are introduced.

Police officers especially require more formal information from social workers, therapists and prosecutors on the outcome of investigations. this is needed not only in terms of court, but also in terms of its affects upon the victim and the child. This will allow officers to become more evaluative and corrective in their technique and approach. In addition, more experience in laying charges is required.

Officers appear to require better means of communication with families as to what their legal limitations are and what they can really do for victims and families in many areas. This will create more realistic expectations for both parties, and appropriate strategies of assistance can be developed.

Officers conducting sexual abuse investigations require support both from their superiors and fellow officers for the difficult work in which they are involved. Lastly, officers must develop the skills of joint decision-making during investigations which allow the collection of "good evidence" and the fulfillment of more than one mandate.

Organizationally, departments and detachments have to permit a degree of increased specialization among officers. This is a difficult issue given available resources, personnel and current agency policies, especially in the RCMP. Goals and procedures, however, must recognize that a child sexual abuse case requires a definitive approach or style. This has to be introduced into procedures and officer evaluation.

Law enforcement agencies will require time for training and policies to increase the experience of a predominantly young force. The availability of female officers to at times conduct investigations will need to be addressed. Not only is time required for training, but time is also needed for investigations. Expectations in an officers performance in such cases well have to be modified. A policy for case-weighing may be required to allow officers sufficient time to conduct proper investigations. This should proceed with adequate supervision, especially for inexperienced officers.

Given the current distribution of experience within departments and detachments, an adequate scheme of shifts or shared investigations should be available to them. The distribution of experience, especially in rural areas, is problematic. Rural detachments will require a scheme of sharing experienced officers, equipment, and permit less experienced officers to assist in investigations.

Some jurisdictions will require the development of adequate procedures for investigations and insure that all officers are aware of and understand these procedures. Procedures should help in developing consistent investigations. The difficulty will be to provide sufficient flexibility in those procedures for officers to adapt their investigations to the nature of the abuse case and the requirements of joint decision-making.

Departments and detachments need both a formal and informal means of communicating case outcomes in the Justice system, especially court, and the Social Services and Mental Health systems. This should be adapted to an informal procedure for evaluating investigation strategies and techniques. This can be in the form of periodic case outcome reviews, either conducted internally or externally, in conjunction with other services. The preference would be externally.

Since supervision is a normal facet of police work, a regular reporting scheme for investigations should be developed which prioritizes major and minor offenses but recognizes the risk-level of the victim or the family. All officers should be aware of this reporting scheme.

Adequate supervision and experience within or outside of the jurisdiction should be made available or shared between jurisdictions which cannot afford the cost of maintaining the resource. This may also require that alternative case assignment criteria and procedures be devised by departments or detachments when suitable expertise will or will not be available for investigations, especially in major offenses or high risk situations.

There has been considerable mention as to the length of the court process and its effect upon victims. We also find that delay of charges and length of investigations are problematic. Length of investigations can be modified, but with difficulty. Policies and procedures with the Crown, however, should be devised which expedite the decision-making process. It affects both victims and others involved in an intervention, thereby decreasing the speed or feasibility in some cases of response.

All cases of sexual abuse are not the same in terms of severity or complexity. What is of particular importance in our observations is the need for 'prioritization' of "high" and possibly "moderate" risk cases. The use of information and decision-making on such cases should be a planned, integrated, joint-effort between police and social workers. Consequently, more emphasis should be placed upon coordination and communication, formally and informally, and should be reflected in protocols.

Some effort, possibly through training and policy, needs to be placed upon the "buffering" and understanding the pressures children undergo during investigations which may result in denial or recanting. This also requires that police more accurately assess family situations. This can be accomplished through training or relying upon information available from social workers who are more heavily trained and experienced in these areas.

The current protocols for investigations may be problematic in many situations. Both law enforcement agencies and the Department of Social Services should devise much more effective set of protocols which provides for investigation planning and sharing combined with a formal means of communication. These protocols should be evaluated and revised regularly.

Police jurisdictions should insure that all officers, especially those who may conduct investigations, be aware of and understand these protocols. More importantly, supervisory personnel must monitor how closely they are followed. Reporting procedures can include protocol information and evaluative comments and administratively collected on a regular basis.

Protocols should only be the foundation for a cooperative and coordinated relationship. This requires that both social workers and police officers understand each others mandates and assist in fulfilling those roles, including the techniques and decisions they must make. Both will require enhanced skills and may best be accomplished through joint-training.

Protocols should ensure sufficient sharing of information in a timely fashion for effective decision-making. They should also insure sufficient access to each other "after hours" and in emergency situations. The status of cases, especially those considered to be "high risk," should be communicated frequently. More on protocols will be reviewed in the inter-agency section.

One issue which has only partially arisen here is the effect of "therapy or counselling" upon evidence. It will become more significant in several years. This issue requires considerable discussion with a number of agencies well before it becomes major difficulty in the courts.

Law enforcement agencies in short, are separate jurisdictions within Prince Edward Island. There are two requirements based upon our observations. First, a joint-planning effort is required between each jurisdiction, Social Services and other reporting agencies which reflect, but are not limited by local resources and political realities. Second, the jurisdictions themselves, given the current distribution of resources, need to plan together through possibly the Police Chiefs' Association and/or Officer Association the sharing of expertise, availability, training and procedure development. Given the occurrences of demand for investigation, there appears to be an inefficient use of resources when other jurisdictions may require those resources.

VIII.4 SOCIAL SERVICES

The Department of Social Services operates through five regional service centers in Prince Edward Island. Each has its own regional director. The Department becomes involved in cases through investigations, referrals and by providing direct services to clients and families. Consequently, interventions are regionally based, three of which would be termed rural centers. Summerside and Charlottetown, however, deliver services to rural residents.

In our research on social workers and their involvement in sexual abuse cases, extensive data were also collected for the examination of structural, process and policy needs within the Department. The background on this research was presented in the section covering service workers. Other data was collected in interviews, meetings and private discussions. It will be reported at the end of this section.

Many organizations have numerous policies and procedures, excluding protocols, for a Social Worker's activities in a child sexual abuse case. Workers were asked, in their opinion, how precise were these procedures for sexual abuse cases? Twenty-eight percent (28%) felt they were general to very general. Thirty-five percent (35%) indicated somewhat specific, and 31% felt they were quite or very specific regarding sexual abuse cases.

In terms of flexibility, most workers (75%) felt they were somewhat flexible in dealing with sexual abuse cases. This, in essence, gives a social worker some options in case procedures. Twenty-seven percent (27%) thought there was some to little significance to their everyday casework with sexual abuse cases. Obviously, specificity and relevance should be examined by the Department for cases of sexual abuse involving children.

In some agencies, social workers are held more or less accountable for particular types of cases. Approximately 72% felt they were quite or very accountable for their interventions into sexual abuse cases, 28% said somewhat or little. In addition, the majority of social workers (83%) reported the level of accountability was about the same as cases not involving sexual abuse. Fourteen percent (14%) reported more than usual. The obvious policy question for an intervention model is whether or not sexual abuse cases should have more worker accountability or not, and if so, how much?

Workers felt that they primarily rely upon themselves to determine whether they have handled a case of child sexual abuse "effectively." Twenty-five percent (25%) indicated they relied upon fellow workers, supervisors, or possibly, directors for feedback on effectiveness. Likewise, they tended not to rely on others to determine if a case had "good" outcomes. Fourteen percent (14%) indicated they did so a lot of the time or always. Social workers varied considerably as to how frequently they discussed cases with a supervisor or director. In the past month, 17% indicated they had been discussed once, 17% twice, 38% weekly, and 28% daily. These percentages will vary by the worker's experience and position. In some cases, however, they may be discussed too infrequently if a worker is relying upon feedback for direction. Lastly, some workers appeared to want more practical suggestions in sexual abuse cases. Thirty-eight percent (38%) of the respondents indicated this.

VIII.4a PROTOCOLS

Protocols have been identified by the Advisory Committee and many others as a major factor that can influence the coordination of an investigation. The coordination of an investigation directly affects two outcomes - evidence for prosecution and protection of the child and sometimes the family. The presence and awareness of protocols does not produce or insure coordinated investigations, nor positive outcomes. They are only a component involving skilled investigators, appropriate planning and role-sharing. Consequently, the protocols may be present, but ineffective in creating coordination or favorable outcomes.

Social workers were asked if they had any difficulty operating within the current protocols for sexual abuse cases. Thirty-eight percent (38%) said they had no difficulty, whereas 62% had difficulties. Thirty-four percent (34%) had some minor difficulties, and 28% indicated some to a lot of difficulty. When we control for whether the respondent was an intake or long term worker, the percentages of those experiencing difficulties as intake workers was higher.

When asked how frequently they have been followed, four percent (4%) said never, 7% once in a while, 30% said sometime, and 59% said most or all of the time. Obviously for some workers, protocols are problematic in sexual abuse investigations and may be ineffective for others.

Some of the problems concerned the time requirements because of their feasibility or what may be best for the child in relation to the protocols. School was mentioned because the protocols suggest that interviews be conducted in school. Obviously, as others mentioned, this can create difficulties for victims due to confidentiality and police or school officials, especially in rural areas. In some cases, social workers do not have copies of the protocols. Most were concerned that they do not at times fit the best needs of the child or, the child requires a more timely intervention than the protocols recommend. Likewise, there were comments to the effect that following the protocol through prosecution may not fit the interests of the child or be too traumatic for the child.

The nature of protocols and the involvement by police significantly affect the nature of investigations and their outcomes. The following review is concerned with fairly average cases. As we know, protocols rarely are directly applicable to very problematic cases.

Many workers (48%) felt that the police had very little understanding of the current protocols. This corresponds to some degree with data from police officers. Sixty-three percent (63%) of the workers felt they were followed most of the time, 37% indicated they were followed about half the time or less based upon their experience. Likewise, 65% felt they experienced some or a lot of variation in the understanding of the protocols and 51% experienced some to a lot of variation in following the current protocols.

When asked what happens when they are not followed, a variety of responses were given. Most said coordination in the investigation was significantly reduced. This can mean delays in the investigation and problems with evidence, case-building, and charges. It means mixed messages to the victim and family and, obviously, varying degrees of confusion on the part of the clients and the investigators. One interesting comment concerning the protocol and police presence was the effect of intimidating the victim or the family.

The results can be numerous. The most common result would be a delay in intervention and services. Obviously, time affects evidence and creates problems in prosecution, especially in legitimate cases. Cooperativeness of the family can diminish if an investigation is uncoordinated. Repeated interviews, as reported earlier, can increase re-victimization.

It is clear from data from both police and social workers, that skilled, sensitive, and knowledgeable investigators for both the purpose of protection and criminal charges are required. Protocols are an "insurance policy" towards establishing coordination. They do not produce it or guarantee positive outcomes. They try to insure a process. It is quite clear that a new scheme of intervention must be based upon a set of protocols that are functional, flexible, and understood by both social workers and police. In addition, coordination will increase if both understand and contribute to the others' role responsibilities with a common goal in mind - the victim. Protocols must be extensively revised. The revised protocols should have as their major goal - the victim and insure the process of coordination, they can never insure coordination nor produce it.

VIII.4b CASE DECISIONS

Child sexual abuse cases require an inordinate number of decisions, some in crisis or emergency situations when victims are at high risk. Obviously, as in other professions, people will have varying degrees of difficulty with different types of decisions. Sometimes this is because of the complexity of the case, the nature of the evidence, experience and high states of emotions, etc.

Social workers were presented with a schedule of case decision-making areas closely associated with sexual abuse cases with the intention of discovering those areas where workers could use additional training, experience, and supervision. The decision of when to investigate a complaint, especially based on "hearsay," with insufficient information can be a problem. Forty-five percent (45%) said they had no difficulty in this area, 38% reported some minor difficulty and 14% felt there was some difficulty.

After a decision has been made to conduct an investigation, decisions are required to determine "how" to conduct the investigation. This area includes numerous sub-decisions. Seventy-five percent (75%) had no or little difficulty, a few (25%) had some difficulty in these areas. No social workers reported a lot or extreme difficulty. Most workers had no or minor difficulties in deciding upon the "depth" of an investigation. About 25% reported some difficulties. Validation seemed slightly more problematic. Approximately 40% of the respondents indicated they can experienced some difficulty with these decisions. This percentage will increase as the case becomes more difficult.

In areas such as determining the risk level of the child, 78% of the workers had little or no difficulty. Removal of the child from the home was somewhat a more problematic decision for the respondents. Fifty-five percent (55%) said they had no or little difficulty in these decisions, 25% had some difficulty, and 18% had a lot or extreme difficulty. This is consistent with other casework research in child protection.

Workers (81%) appeared to have little difficulty in determining the safety of the child with the non-offending parent or parents. Approximately 44% however, indicated they sometimes had difficulty in trying to have the offender leave or to be removed from the home. Twenty-two percent (22%) reported some difficulty in decisions regarding approaching the court for temporary or permanent applications.

Many workers (44%) found decisions on an appropriate placement for a child sometimes difficult and 21% found case plans for sexual abuse victims a difficulty at times. Only a few workers had difficulty with how long services should last for a victim.

Prioritizing involvement in sexual abuse cases was sometimes frequently difficult for 29% of the respondents. Very few workers had some difficulty with referrals (11%). The difficulty appeared in terms of "to whom." Thirty-four (34%) indicated some difficulty in this area.

Workers, however, also monitor clients in terms of how well they are doing. They tend to have some difficulty in deciding when to "push" a client to try and effect change. Fourteen percent (14%) had no difficulty, 32% had a little difficulty with these decisions, and 54% had some difficulty in this area. On the other hand, only 23% had some difficulty in giving guidance beyond normal casework. Last, 29% had some difficulty in decisions surrounding when to close a case involving a victim who had been sexually abused.

It is interesting to note that many workers felt they could use some form of a psychological assessment or evaluation of victims before they made decisions in cases involving sexual abuse. Forty-two percent (42%) of the respondents said this would be helpful a lot or most of the time and 36% said some of the time.

It is clear that the Department should conduct a more thorough analysis of this data and address the difficulties in decision-making through case review, evaluation and adequate training. Moreover, consistent policy in many of these areas improves effective decision-making even in complex or crisis situations. One very important area of concern are the number of cases involving very young children, especially under four or five. validation and the collection of evidence from children is extremely difficult. The Department and Law Enforcement Agencies must consider the development of a "special expertise" in approach and technique of investigation for these children. An expertise which may not be required by all social workers or police officers, but available to them directly or on a consultative basis in the Province.

VIII.4c AUTHORITY

Because of the intrusive nature of most interventions, especially those involving child sexual abuse, many people become very upset or shocked by an investigation and the actions which follow. This is especially true in child protection situations. There have been constant comments that many families and children fear social workers. This perception will directly influence the levels of cooperativeness, by both the victim and the family in the intervention, and can slow the intervention down at times.

Workers were asked questions about how well people understood their authority. Families and victims tend not to understand. In addition, other agencies do not understand or are not aware of a social worker's authority. Eighty-six percent (86%) of the respondents felt that agencies had little understanding of their authority in sexual abuse cases. At the same time, respondents felt that in many cases, agencies did not understand or were not realistic about what a social service intervention can do because of legal constraints or mandates.

In a needs assessment, the role of social workers in interventions is very important. Also, the nature of the role and how it is performed is critical in sexual abuse cases. We recognize the need for more explanation by Social Services workers and the agency to increase the understanding of these roles, mandates and legal constraints to clients and other agencies. It should heighten cooperativeness to some degree in conjunction with its judicious use to force "outcomes" and the necessary policy changes.

VIII.4d REFERRALS

One of the major roles of social workers in child sexual abuse cases is to link the child and family, if necessary, with suitable services during the course of an intervention. In the past year, the respondents referred ninety-five children for therapy, an average of approximately six per worker. Some respondents (n = 7) had not referred any children for therapy in the past year. Most workers had also referred a half or more of the families of victims for therapy. Those referrals were made to a combination of public and private agencies.

Only 33% of the respondents felt they were very familiar with the approach or operating philosophies of these agencies. Forty-four percent (44%) were somewhat familiar and 22% were only slightly or not familiar with the agencies. Forty-six percent (46%) felt the agency only somewhat or slightly fitted their clients needs. In general, only 38% felt it fitted many of their needs and 16% of those agencies fully fitted the child's needs. Fifty-eight percent (58%) were very or fully satisfied with the client outcomes and 27% were somewhat satisfied.

The major difficulties experienced were waiting lists and delays in service. Many felt the therapists they were in contact with were "over worked." Difficulties with referrals occur not only when making them, but when dealing with the willingness of the victim and family to deal with the abuse and to stay involved in the case plan. In other words, seeing that both parties follow through with the therapy is problematic. Several workers felt there were not enough people capable of doing the type of therapy that are necessary for children and families in sexual abuse cases..

Most workers (73%) felt they had some influence over the services that were provided for either children or families. Most felt, however, they had very little influence - only 10% felt they had a lot. Sixty-two percent (62%) felt they had no influence in other support services to their clients outside of Social Services. This presents major difficulties in devising and following an integrated and effective case plan.

Making the decision on a referral (and to whom or to what agency), is a function of many factors, especially in the case of sexual abuse victims. Workers were taken through an exercise of ranking some common factors used in making referral decisions. A number of common factors were listed and they were asked to rank each from one to five in terms of the importance placed on each criteria when making a referral. The following table represents these results in tabular form. We caution the reader that these are general rankings. Case specific rankings would reflect situations concerning the victim, urgency and other factors.

A series of non-parametric tests (Q, W, etc. coefficients) were calculated for this data and many coefficients were inter-consistent and had moderate to high levels of significance (Chi-Square based). Rank percentages should be read from left to right. What is significant in the above table is that referrals are not primarily made on the basis of the victim's needs. The split in % ranks over competence and availability indicate that both are either primary for some respondents or strong secondary ranks. Past experience is important with nearly half the respondents (Rank 1 or 2), as is suitability. Additional statistical analysis will indicate a moderate to moderately high degree of inconsistency between respondents on these criteria for referral.

TABLE 8.1

Ranking of Referral Criteria

Criteria	% Rank One	% Rank Two	% Rank Three	% Rank Four	% Rank Five
a. Nature of Victim Need	70%	19%	7%	4%	0%
b. Competence of Therapy	37%	19%	30%	7%	7%
c. Availability of Service	8%	35%	8%	35%	13%
d. Past Experience or Trust of Therapist	33%	23%	19%	27%	8%
e. Suitability of Therapy	19%	24%	24%	19%	14%

The obvious question for a needs assessment is, to what degree does referral best fit outcomes for the client? More important, is the current system of referral operating more on the basis of expedience or "best" short term solution for a client or family given certain constraints (e.g., availability and adequacy)? More will be discussed later on this topic and a further analysis will be required in the planning process for the model.

Communication between social workers and other services is essential in an effective intervention in cases with children who have been sexually abused. Workers were asked an inventory of questions concerning the amounts of written and verbal communication they received from other services they made referrals to or services within Social Services. The survey items concerned reports, reviews, problems and case outcomes in that service.

Sixty-one percent (61%) of the respondents received very little or no written communication about their referrals to therapists in their agency, and 36% received some information. Within social services, 35% received little or no information from other services, 65% received some to a lot. In terms of support services outside of the agency, 62% received little or none. The remaining 38% said some written communication had been received.

There was a tendency for more verbal communication between workers and therapists and workers within their own agencies about clients, but only with a small number of workers. In general, the same pattern existed that appeared with written communication. Fifty percent (50%) received some to no verbal information on their clients - 45% received a lot. Within social services, 40% received little or no verbal information on their clients, 48% received some, and again, only 12% received a lot of verbal information. Verbal communication from support services was minimal. Seventy-one percent (71%) had some to no verbal information about their clients while 29% had little or none.

verbal information. Verbal communication from support services was minimal. Seventy-one percent (71%) had some to no verbal information about their clients while 29% had little or none.

Among other things, information flow is essential to the monitoring of clients, the effectiveness of services and the modification or adjustments in case plans. This data highlights the very informal nature of referral and social worker contact. It also highlights that much of the "system" in place operates well for some workers and as a consequence for some clients. The needs assessment question is: does this ensure equal response and quality of response to all children who have been sexually abused and their families? Later we will discuss these issues in terms of content of communication and the required flow of information in an intervention model.

VIII.4e WORKLOAD

Having enough available time for clients who have been sexually abused and their families is important for good outcomes. Some sexual abuse cases, as we have noted in the current cases, can demand forty to one hundred hours of a social worker's time despite their other caseloads.

One of the most frequent reasons workers had for insufficient time with their clients was the assignment of too many cases. Eighty percent (80%) indicated it was a reason for insufficient client contact time. In addition, changes in their incoming case demand which can change frequently, was a difficulty in delivering sufficient services to children (75%). Most workers felt their skill levels were high enough, but available time was the major constraint.

Internal coordination didn't seem to be as much of a problem as poor external coordination with other agencies. Almost 80% of the respondents said this reduces available time with clients. Changes in client demand frequently appeared as a reason for insufficient service. Approximately 51% felt this often to always reduces client time. This was slightly less so for families (37%).

The constant need to 're-prioritize' their contact and service delivery because of other case demands with clients was seen as a frequent difficulty for most respondents in trying to "follow-up" with their clients. Thirty-one percent (31%) said often to always, and 46% said sometimes this was the situation.

Effective service delivery and follow-up on clients is obviously a function of case demand and case flow. This is especially true with sexual abuse cases when client demands frequently change. This is also evident in our data on emergencies before and after the validation of sexual abuse. An intervention model must be devised with structures and policies to increase the availability of time for children and families. Moreover, it should not reduce available time because of poor levels of coordination.

VIII.4f TIME IN COORDINATION RELATED ACTIVITIES

Social workers' activities vary from day to day. Their primary activities, however, are brokering services, providing direct services or communicating with clients. Our analysis tried to focus on these kinds of coordinating or service delivery activities. As most government employees will tell you, they spend a lot of time doing paper work. We were sure to also include items related to that all too common activity.

Respondents were asked to complete an inventory of activities and to indicate on average how much time (hours) they spent on each activity. Full and fractions of hours were reported. Averages were calculated for all respondents. We must note that in come cases there were large standard deviations on some of these activities. Workers were also asked if they spent more or less time in these activities when the case they were working on involved a child who had been sexually abused. The calculated results are in the following table. These hours were not expected to add up to an eight-hour day, which is sometimes the reality.

TABLE 8.2
Average Time in an Activity

Activity	Regular Caseload Average Hours/Day	% Who Spend More Time
a. Records and Reports	1.5	60% more
b. Supervisory Discussions	1.1	85% more
c. Informal Discussions on Cases	0.8	45% more
d. Coordinating with Other Members of Unit/Problem-Solving	1.6	81% more
e. Coordinating with Regional Office Staff, Responding to Directives or Issues	0.9	55% more
f. Central Office Responses	0.3	23% more
g. Coordinating Outside Social Services	1.3	91% more*
h. Providing Direct Services Including Information to Clients	2.6	90% more*

* Some respondents indicated there was not only more time spent in this activity, but much more time.

Note: These hours are not divided by intake and long term or supervisory positions.

A cursory view of the following table indicates the respondents on average spend about one-third or more of their time in some form of coordinating activity. In addition, another 20% or more is spent in communication, formal communications, and supervisory coordination.

In other sections of this report, issues have been raised concerning effective coordination, coordination skills and "ineffective" coordination. All of these can decrease levels of outcome for the victim and decrease direct contact time in conjunction with caseloads. In sexual abuse cases, the respondents are basically indicating they do more of these activities. In some activities, they do much more.

Previous sections of the report have raised the concern of effective inter-agency communication and coordination. Obviously, a more in-depth analysis of this data is required in planning an intervention model. In any case, it would appear that if more effective means were found for internal/external communication and coordination, more time would be available for client contact and more "positive" outcomes in interventions for victims and their families.

VIII.4g DETERMINATION OF RISK

Our analysis of "risk level" determination in child sexual abuse cases suggests both consistency and inconsistency among workers. These are not "set formulas" for determining risk. Past research indicates there can be considerable variation in this, even in cases that are not based on the sexual abuse of children. Determination of risk influences case decisions and the nature of intervention.

Workers were asked to rate eighteen criteria in the determination of risk and to rank them. The criteria included age and sex, the nature of the abuse, duration, history, parental response, child's behavior, protectiveness and cooperation. Our initial analysis indicated a variation of response on the basis of background and experience, as well as location (although both are correlated in some cases).

Although there was minor to no variation in the criteria based upon the physical nature of the abuse and duration, there were considerable amounts in the child's response and the familial response, although parental willingness to protect was very consistent. We realize the importance of these factors will vary by situation or other factors. Criteria based upon the child's behavior was moderately consistent.

The assessment recognizes that the determination of risk is a complex decision and many times is a judgment call. To insure consistency across cases and locations, however, a further analysis is required for the purposes of procedures, training and policy. Probably the most effective means of implication will be through the supervisory level.

Policies and practices must be devised to help reduce the amount of denial and, possibly, recanting by victims. This should be jointly devised with law enforcement agencies. Some areas of specific concern are the fears children have and the pressures exerted by offenders or families.

The needs assessment has already highlighted those areas which require closer attention in training. In addition, case decisions and coordinative skills should be enhanced based upon the data presented. Workers have specific preferences for more in-service work with experienced social workers training with these techniques should be utilized. This should be combined with modifications in some aspects of supervision and case planning.

Workloads are extremely high in some cases and decrease the available time with clients. A larger amount of 're-prioritization' occurs in many cases, thus affecting the victims' and families' needs. Research indicates that there are a number of feasible schemes for "case weighting" in child welfare cases which should be put in place at the supervisory level. However, our data indicates a degree of instability in some cases. Case weights, therefore, should be periodically reviewed and adjusted to insure maximum time is available to victims and clients in especially difficult cases.

The question of autonomy in human services delivery is always a major problem in public agencies. It appears from our analysis that there is considerable variation in the amount of influence workers have in decisions concerning case plans, the handling of cases and relations outside of social services. It ranges from little or no say to a high degree of autonomy. The degree of autonomy allowed in some areas should be reviewed. At the same time, coordination with other agencies should become part of a more centralized policy. Some of these decisions in child sexual abuse cases should probably be moved to the team level.

At the same time, there appears to be too much centralized decision-making in other areas such as internal coordination and work load. Organizational research indicates that as coordination problems increase, centralized decision-making increases. If coordination problems can be decreased, so should the centralized decision-making in some areas. Consequently, there is more available time for decision-making in referrals, brokering of service and in other areas. In other words, more time and effort can be placed in effective coordination for victim outcomes.

As we review internal coordination data, we realize that there is an immense flow of information in many situations and little flow in others, both formal and informal. A re-examination of these areas should be devised to enhance more effective communications and, therefore, coordination at the team and supervisory level.

Client and family contact appears low in many cases, especially when we consider the information requirements in cases of sexual abuse, as reported earlier.

Last, the percentage of communication which is case work related seems low. Policies should be devised as well as a formal communication structure which enhances available time for cases.

Although the data will not be reported here, it appears that particular elements of job satisfaction and its correlates to worker involvement in cases should be addressed, especially in case work involving sexual abuse cases. In addition, the conflictual nature of unit decision-making should be addressed. Likewise, unit decision-making over coordination issues should be clarified. A more definitive re-structuring and approach to coordination is obviously required. Successful informal mechanisms already seem to be in place in some places to handle contentious issues surrounding abuse cases.

Several work related policy areas appear to require some, but not total, consistency in approach. One area is the issues surrounding families and the goals of case plans. A second and more difficult area is criminal prosecution and family input into those decisions. Likewise, the need to "rescue" children should have more consistency in policy. This, however, is very closely connected to the issue of responsibility and autonomy.

Areas related to the transfer of cases and worker responsibility for cases appears to vary in attitudinal consistency. Its affect on victims and other agencies requires that policy be established in this area. The issue of procedural changes needs to follow. This appears to be not only a need within Social Services, but also a need in agencies that provide other services. Lastly, although contentious, a thorough consideration should be given to social workers' roles when trying to monitor outcomes with victims and families involved with child sexual abuse cases. We recognize the possibility of lack of cooperation in therapy and other aspects of case plans, but it is problematic at times.

Several sources of data in the needs assessment appear to indicate that many decisions made by social workers are heavily dependent upon the psychological assessment of victims and families. Some workers appear to be very comfortable in this area, but others are less so. This seems to be most evident in difficult or "volatile" cases. In addition, referral decisions are heavily dependent upon assessment. It appears that most workers feel that victims and families, excluding extra-familial, require therapy. Decisions or therapy referrals and to whom they are sent as well as the level of urgency may be more functional with assessment prior to referral. The increase in the numbers of referrals puts an increased burden on Mental Health Services. The Department of Social Services may require some internal "mini" assessments or screening when cases seem problematic or potentially at "high risk." This may increase more effective decision-making in many areas by providing workers with more useful information and will expedite the therapy referral process and case plans.

Record-keeping in the Department leaves much to be desired, not only for researchers, but social workers, supervisors, and the Department. Accurate and consistent information provides the means for adequate evaluation of outcomes and case plans. In addition, the Department requires a more accurate means of determining service use, case status, and victim and family characteristics. Information of this nature provides knowledge about case flow, demands and the intensity of both. A system of this nature should be available at the regional level and readily accessible by supervisors. Although massive amounts of information can be collected, only that which provides for the effective transfer of cases and planning should be included. In other words, records and their retrieval should have definite planning and evaluative goals. At present, it is nearly impossible to determine the nature and speed of response to children, as well as the time factors related to the intervention with the victim and family.

The research on social workers indicate that case demand definitely affects contact time with victims and their families and service delivery. It has also been indicated that there is little control over the pace of work and prediction of case load. In other words, there is a high level of uncertainty in many aspects of demand, flow, pace by nature of the type of casework that is involved in child sexual abuse cases. This uncertainty is compounded by the present nature of how decisions are made and information flow from other agencies. This uncertainty has to be more thoroughly analyzed and reduced. The strategy for the reduction of uncertainty has to be part of an integrated approach to victims and family. The approach itself will reduce uncertainty.

Lastly, some reorganization of Social Service response or specialization should allow for and have as an objective the increase of time availability for the monitoring and "follow-up" of cases of child sexual abuse. This will be definitely tied to the issue of case transfer and specialization within the Department.

VIII.5 VICTIM SERVICES

Although Victim Services is an organization within the Department of Justice, its involvement in cases of child sexual abuse requires that it be reviewed as a distinct agency. In addition, its potential in an integrated approach also requires that it be reviewed in the later section on the assessment of inter-agency relationships.

Victim Services, based upon our review, requires a clarification of its mandate and a more definitive role within the Department of Justice. At present, with three personnel it is "required" to interact with a variety of victims who need assistance providing a number of services ranging from referral to other support services to witness preparation and support in court.

The agency is a major means of contact with a victim or family once a case has come to court and Social Services or Therapeutic involvement has decreased or ceased. Therefore, it is a major component in the information flow between the victim and the present "system of response" and should be capable of recognizing and identifying problem areas for the victim.

From our observations, both the time available for Victim Services to assist victims is low as is the time available to prepare child witnesses. Due to the inadequate information flow within justice, preparation time for a child is sometimes jeopardized. It appears that Victim Services requires at least three weeks lead time to schedule resources and prepare a child to testify. Obviously, better information flow within justice would provide for a more scheduled and effective use of a agency with limited resources given its tasks. A more clear definition of roles with children who have been sexually abused would also assist in the effective use of this resource. Moreover, since there is no specifically defined child witness preparation program - its comparative effectiveness to "one on one" preparation should be decided and the necessary resources put in place.

The more effective use of resources in Victim Services would also result from a clarification of roles between the agency, and the Police, Social Services and the Crown Attorney. To some degree, a protocol is required that is case-flexible. This has been identified by personnel in other agencies, as well. Victim Services could then play a responsive role to children's needs in the court system. In fact, as mentioned previously, it may be capable of increasingly support them in court. The exact nature of that support should be discussed and defined with the child's needs being the most important criteria.

An issue which requires correction is the relative awareness of Victim Services, internally and externally. Victims and families are incapable of trying to obtain assistance, if they are not made aware of its services. Secondly, the case of access should be enhanced for victims and their families. Victim Services, although by mandate is oriented to the victim, it should be more capable of playing a supportive role to the family, when required, during the court process.

Victim Services because of its information requirements should participate in a more centralized form of information flow from both the prosecution and the court. Much of its roles is dependent on "timing." A regular reporting scheme with necessary information on case status etc. should be available to Victim Services personnel, both internally and externally. External communication will be discussed in the next section on inter-agency integration and requirements for coordination.

VIII.6 SUPPORT SERVICES (VOLUNTEER AGENCIES)

When children and families confront the "system" of response which is in place, they to varying degrees have access to a number of formal services within public agencies. Variation in access to those services increases with location, both urban and rural. In therapy, however, they typically confront waiting lists which may become substantial delays in assessment and treatment. At the same time, children require a variety of services in different sequences, as may families. In short, children and families may require support first, treatment or a varied combination of both. The sequence of response may be very critical in many cases.

In the present system, some support services are not comprehensive and unevenly distributed. Some are operating with insufficient resources for their demand and services are very goal-specific, and not definitively including children. The agencies roles in response to children and families remain unclear, as do some of their personnel in terms of their participation in an intervention. Clarification of expectations, roles, resource development with volunteers, and a defined part in an integrated approach appear to major difficulties. As well, more awareness, understanding and clarification of roles with others in an intervention must be addressed.

The obvious difficulty for these agencies, at this point in time, is the lack of a defined systemic intervention which would allow them to adopt, adjust and develop new services to accommodate the supportive needs of children and families. This needs assessment will hopefully modify part of this situation. In short, it is difficult for volunteer agencies with specific social goals to accommodate themselves to a more comprehensive approach to children and families, if none exists.

Referral into and out of both support agencies requires closer analysis and clarification, as does expectations for victim outcomes. In addition, it is difficult for public and private agencies to make referrals in both rural and urban areas, due to a lack of understanding in operating philosophies, distances between victims and families and services, and a lack of awareness of what an particular agency provides as services, who is available for support, and the nature of outcomes.

We have noted that in Mental Health, Social Services and Private Agencies that referrals are made on the basis of familiarity with the person to whom the referral is made, trust, and having "some" independent sense of the nature of outcomes for both victims and their families. Levels of awareness and information flows must obviously increase.

In this assessment, it has become apparent that there are definite needs associated with both children and families. At the same time, we identified vital and available resources to fit some of these needs. But, many remain underdeveloped and under-utilized. The system development phase will have to take account of the degree of splintering in services, willingness to play a role with children and families, addressing some part of their needs, and participate in variations of residential services.

The proposal has frequently identified the need for support of children and families, especially in cases where it is not available from families or relatives or not likely to develop in the short term. Means have to be developed to address these situational needs, so that more children have access to support despite the nature of the abuse situation and accompanying familial situation. If not, then more "gaps" in any scheme of response will develop and the probability of problematic cases and multi-problem families "falling through the cracks" increase.

Operating philosophies in conjunction with goals of services have to become more understood and clarified in relation to the presenting problems and family situations that arise in child sexual abuse cases, if an integrated and equal response is made available to children and families. The difficulty of operating philosophies and referrals has to be addressed to adequately use what facilities and services are available. This will become increasingly more critical when an integrated response is more fully developed.

Support services in agencies have to be developed which provide for an ease of access for children and families and sufficiently available to rural areas despite case-situational problems. Likewise, we must constantly recognize the right of the child and family in terms of their preferences.

Any system of response, requires a means of "follow-up" once a child has begun to leave or have left the more formal parts of a response system. We have frequently noted that this is one of the means of identifying the development of additional problems or appearance of delayed difficulties that a victim may experience. This has become increasingly less feasible as case loads and client demands have increased in Social Services, Mental Health Services and Private Agencies. If this role has to increase, then more public agency resources are required to adapt case-assignments and case-loads.

On the other hand, volunteer agencies or private agencies can play a role in monitoring clients and follow-up, when necessary. Likewise, they can recognize, support and advise formal response agencies that additional services, treatment or support is required. In addition, they can provide services which public agencies are "not capable" of nor have the resources to deliver. In summary, vital resources are available to meet some of the needs of victims and families. The agencies, themselves, have to provide input and adapt to an integrated approach whose major goal is equal access of children and families to services which provide safety and healing.

VIII.7 MENTAL HEALTH AGENCIES

Mental Health Services provides service to children and families through three centers and one hospital. Each has its own director and delivers services on a regional basis. Some centers, however, provide more specialized treatment for the entire Province. Services are also provided by two Private Agencies in Charlottetown. This review will address both simultaneously or independently as required.

One of our initial observations and frequently mentioned by others in this report, is the supply of therapists, availability of service and sufficient levels of training. These difficulties which will be addressed later can be attributed to some extent to insufficient clarity in the mandate of Mental Health Services and the lack of goal specificity with regard to its role with children and especially those who have been sexually abused and their parents, both offending and non-offending.

To some extent the need for trained and willing staff should depend on a clear definition of the role of Mental Health Services in an integrated response to children and families. This needs assessment will assist in that definition and the development of an integrated response. However, the gaps and distribution of service need which we have identified in both rural and urban areas have to be analyzed and more closely matched to existing resources. This should determine where mental health resources should be developed as part of an overall system of response, especially in rural areas. It is quite feasible that some service can be redirected to other formal or informal resources that exist or will be developed.

At present, Mental Health Services operates a "generic" type service which operates to fit all the needs of the population. At present, Mental Health Services operates a generic type of service which must fit all the needs of the population. In a province which is primarily rural, the agency must serve the needs of all age groups with a multiplicity of mental health problems. Attempting to provide services to child with an adult model of treatment services is difficult since there is no mental health system specifically defined for children. To some extent the response to children becomes somewhat diluted. In essence, children who have been sexually abused, have not been defined as a separate and distinct goal for a service response. In addition, there is no defined delivery-sysstem for services to children who have been abused. This implies that there is a need to 'prioritize' programs and 're-prioritize' service resources to adapt to the needs of children who have been sexually abused. Mental Health Services administrators and therapists struggle with this problem frequently.

If a system of response is devised for children and families which requires an integrated approach, the goal structure and resource 'prioritization' in terms of funding and staff will have to reflect this responsibility for comprehensiveness of service and access to services in all of the Province. This process will have to commence during the process of system development.

The current response by Mental Health Services is part of many conflicting demands for services. Few specific programs have been designed for children, although attempts have been made to address this problem. Due to a lack of resources and few specific programs, both training, and the time available for training in these areas has suffered. The current response is also a function of therapist's interest and aptitude to do work with children, especially those who have been sexually abused. This is obviously associated with issues and the effects of goal specificity.

Communication, as previously mentioned in other agencies, is a common difficulty which has to be addressed. In Mental Health Services and Private Agencies this can be between Centers, and on occasion at the therapist level within the agencies. Information flow is critical if resource knowledge, expertise and treatment effectiveness are to be shared. This problem is also critical in the communication between public, private, and support agencies.

Communication between the referral agency and mental health agencies has been frequently identified as a problem. Many service-providers make decisions on the basis of the information they have about the victim and the family. (e.g. treatment status, effectiveness, new problems, projected rates of improvement, etc.). This situation is not specific to mental health agencies, it is systemic. A set of standardized means must be developed, possibly centralized, in mental health agencies which permits other decision-makers to gain regular information about clients, families and, at times, offenders. This will require joint-planning and establishment of these procedures by mental health with input from other direct service providers. This is also an inter-agency problem and should be addressed accordingly.

Assessment time in Mental Health Services requires the use of moderate amounts of service resources,irrespective of the nature of the presenting problem in a referral. As an initial response to referrals, it is time consuming for therapists, especially those few who specialize in responding to children who have been sexually abused. The obvious problem to address is - can there be a more effective use of time to allow for more direct client work? Since many referrals come from Social Services, can screening and assessment be shared? If so, referral effectiveness can increase, as well as resource use, and time availability for clients should increase.

Case conference time is moderate to high in Mental Health Services when the child has been sexually abused. This can be in terms of either formal and informal communications in the discussion and review of a referral. There may be other technological means of decreasing this time and using it more effectively with other agencies workers in formal planning and follow-up with clients.

A commonly mentioned difficulty in Mental Health Services and by other agencies is waiting lists. Obviously this is a result of resource availability, sufficient trained staff, and the use of resources. In any case, there may be many organizational and budgetary explanations. Although agencies currently use priority systems for clients with urgent needs, there appears to be difficulty in matching definitions oof urgency between agencies. Children, on the other hand, frequently don't have time to wait, their needs can be urgent. The response to their needs is a function of the source of referral, in terms of the identification of need and the definition of urgency and the professional who takes the referral and their recognition of the identified needs and definition of urgency.

One means of responding to this sistuation is by modification of waiting lists through changes in the nature and function of the referral process. Attempts have been made in the area, and will require additional refinement. Other innovative means of processing and manipulating lists on a regular basis due to the nature of client demand and urgency should be possible. We should note, that the manipulation of waiting lists is still a function of the quality and quantity of "incoming information about the victim and the victim's situation. Changes in the area of referral information are also required.

With the current overall demand for services, Mental Health Services finds itself trying to 're-prioritize' their response. In some cases we can note that there is a narrowness in the response to victims which does not fit all their needs. As well, there may be too broad a response trying to cover all their needs. What seems to be a potential option for better addressing the needs of victims and families, is to increase the number of therapy and support options by trying, "although difficult," to separate types of therapy and support and use alternative means of delivering these services. As a consequence, we may have a more effective use of therapeutic resources either through public or private agencies. In other words, after assessment a treatment intervention plan which coincides with a Social Services case plan can jointly make the best use of defined options. Options can be for both internal and external services, especially in terms of some support or counselling functions. These functions can be increasingly provided by Volunteer groups, guidance counsellors and private agencies. As well, some therapeutic functions may be more adequately responded to by resources in private agencies or other public agencies.

One of the major difficulties in all agencies with "tight" resources is to deliver services with the client's best interest in terms of both sequence and flow of service. When resources have decreased the availability of services, mental health agencies try to standardize and schedule their service to create more efficient use of their resources. However, as we have noted earlier, in both victim, family and social worker data, interventions do not always meet the timing or flow of needs. Treatment interventions and the options used must have a flexibility in its sequence and scheduling, rather than being a function of standardizing clients and the timing of response to their needs.

Accountability and evolution of outcomes have been identified in all the agencies that we have reviewed. Evaluation in terms of how effective was the intervention in producing particular outcomes for clients and families, and how accountable was the intervenor or service provider. People who make referrals and those who must examine the entire system of response ask "what treatment works" and "with whom does it work best?" Are there more effective ways of responding to children with a variety of needs? Are there more efficient means of utilizing treatment and support resources? This not only applies to mental health services or a service-provider, this is a requirement of the entire combined effort of trying to respond to children and families.

Effectiveness of mental health interventions and those who provide treatment and accountability has been a very difficult and contentious issue. It becomes a complex issue of types of therapy, philosophy of approach, and professional autonomy. This issue has to be increasingly addressed by Mental Health Service Agencies, if it is to respond in an integrated manner with numerous other agencies to children and their families. Not only are victims and families affected by intervention effectiveness, decision-makers in other agencies are also affected.

Another area which requires review by Mental Health Services is the most efficient use of psychiatrists, hospitalization and hospital based programming for children who have been sexually abused. Again, the issue is the use and availability of suitable alternatives in outpatient services or the use of different treatment modalities. This would obviously include orientations to underlying pathologies in child sexual abuse cases and the most effective form of response to victims and families.

As in Social Services, there is a requirement for more information in planning the response and resource requirements for victims and their families. Mental Health Services is currently undergoing computerization, and it would be advantageous to include means by which they can project, based upon the distribution of Mental health problems and incidents of cases of child sexual abuse including age, sex and other criteria, the requirements for adequate response to children in different areas of the province.

There are a number of approaches, for example "rates-under-treatment" that can give estimations of service match to need. In addition, data on population distributions can be combined with current MIS information to obtain projected absorption, retention and service-closing indices. Obviously, cooperation with other agencies in both information-sharing about clients and joint-planning would be mutually beneficial to each agency, and most beneficial to victims and their families.

VIII.8 SUMMARY STATEMENT

To a great extent most of the data in this section of the report was collected in a very cooperative and confidential manner. Much of it has been reviewed here. Some specific forms of information on structure and policies will be directed along with recommendations to specific agencies.

This section has reviewed the many agencies that respond to children and families who become involved in sexual abuse. It has not specifically examined all the agencies within the Justice system. However, their views and concerns have been discussed in Sections VII and II.3.

It appears that agencies are aware of many of the requirements within their own agencies. Some have even begun to change areas that were identified. As a needs assessment, this section of the report has focused on problems and difficulties within agencies that require changes to more adequately respond as a singular agency to children and their families. In this sense, needs identification and assessment are negative processes.

despite the negative nature of this process, we have found many staff and directors who have been extremely cooperative. This can be attested to by the comprehensiveness and completeness of our data collection. Second, since we have focused on needs, there has been no time to focus on strengths of which there are many. Staff respond frequently and to the best of their ability given numerous constraints. Directors and other senior staff frequently try to juggle resources, policies and priorities to respond to children and families. One of their major strengths is that this section and the next are in this report. It is indicative of their desire to change the current system of response.

The section has identified a number of difficulties and constraints which are internal to each agency. The reader will frequently note, especially in the next section, that some problems are a function of the actions of other agencies and their staff. An agency may solve structural, process, policy and goal deficiencies within, but most difficulties will not be corrected unless direct-service providers and agencies solve mutual and systemic problems together.

An adequate system of response to children and their families is not the total of a number of independent adequate agency responses. It is the sum of a number of adequate interdependent responses which collectively contribute to meeting the needs of a child who has been sexually abused and their families.

IX SYSTEM OF RESPONSE AND INTER-AGENCY RELATIONSHIPS

IX.1 CONCEPTUAL BACKGROUND

Tower (1989) has poignantly noted that if parents, and we should add victims, can pay the price of stigma they will get assistance in cases of child sexual abuse. We can also note that there are no guarantees, though, on the nature, quality and delivery of that assistance. Finkelhor (1984) suggests that the lack of collaboration, minimum concern for procedures, lack of mutual objectives and case-management may increase the probability that the system can do more "harm" than help. Clearly, services and their delivery are both dependent on the functioning of agencies and the delivery systems between agencies (Kolko, 1987).

Although several authors have described the possible effects of agencies on victims of child sexual abuse, such as the duplication of services (Reid, 1979), the maze of bureaucracy (Costin, 1979), and follow-up services (Tower, 1989), research has not systematically examined the complex problem of service delivery and its impact on sexual abuse victims.

IX.1a SERVICES AND VICTIMS

In the case of victims and their families, both quickly become part of a very complex set of processes following the reporting of the abuse and disclosure. Unlike many other human services, the system's response to sexual abuse victims and their families involves a number of agencies through which intervention, legal and therapeutic responses are made to a victim. In essence, services are provided, if they are provided, to a complex problem on the basis of mandates, organizational goals, and, at times, conflicting orientations. In any case, to maximize the support to the victim and the family the service actions or responses between agencies must at least be compromising and coordinated to ensure that the supportive elements be increased and the victim is done no "new harm."

Needs assessments, less so in sexual abuse cases, have typically focused on client needs and their satisfaction with services. Assessments, however, devote virtually no time to program variables (connected to services) and the structure of delivery. In short, one of the major maxims in organizational research is ignored. That is, services may have good content, but delivery may significantly reduce any beneficial outcomes or even injure clients. Therefore, the system of delivery itself, and service-providers should be critical elements in any needs assessment. We should also emphasize that service workers carry-out the tasks in programs in a service response to victims, but service managers (administrators) create and maintain the conditions through and in which the service is delivered, irrespective of content (Bosserup and George, 1980).

The goal of the needs assessment were not only to assess risk, service need and utilization, but also, to assess service structure needs and the degree to which organizations act in a concerted manner to achieve, if any, "mutual objectives" for victims and families. This initially implies that levels of coordination between agencies must be assessed for problems and resources that will influence the effective and beneficial delivery of services (Tessler and Goldman, 1982).

IX.1b SERVICES AND SERVICE PROVIDERS

In any examination of the provision of services to the victims of sexual abuse and their families, one must distinguish between the roles of the service-provider, the role of the service agency, and the roles of service agencies as part of a "delivery system." With regard to the practitioners, organizational research, as well as experience, has established that their roles are to varying degrees constrained by organizations through mandates, goals, structures and operating technologies (Perrow, 1965; Scott, 1964). The operating technologies are both the services and their delivery. Simultaneously, the service organization, especially in a multi-problem case is constrained by other organizations with similar elements as part of a larger intervention "delivery system" that contains varying degrees of coordination and fragmentation (Aiken et al., 1975). With these factors in mind, the current proposal makes a distinction between the needs of service providers, agencies with delivery systems and delivery networks which are comprised of a multiplicity of agencies (Lehmen, 1975).

The critical importance of organizational environments has been documented frequently because of their influences on what goes on within and between service organizations. This analysis recognizes the fact that a delivery network of services to the victim of child sexual abuse and their families is greatly determined by organizations, their environments and the relationships that exist between organizations (IOR). All directly affect the delivery of services.

The needs assessment has examined many areas of organizations which most significantly affect the integration of services -- mandates, protocols, IOR, networks, and awareness of child sexual abuse. Some of which are necessary preconditions for a coordinated response. If not present at a certain level they become barriers to the development of a response system.

In the past two decades, major changes have emerged in both the size and scope of the human services provided by public and private agencies. Two problems have concurrently evolved -- the supply of resources and coordination of services due to increasing program and organizational complexity. Of central concern to the current proposal is the problem of coordination. Many of the problematic aspects of services are well known -- fragmentation, discontinuity, unaccountability and inaccessibility (Piliavin, 1968).

Aiken et al. (1975) proposed and demonstrated that a major problem in the delivery of services is and remains to be the multi-dimensional *nature* of coordination. The barriers to services and their delivery have been identified by many (March, 1965; Piliavin, 1968; and others). They have included fragmentation, accessibility, discontinuity, accountability, dispersal, presence of interest groups and professional ideologies. These difficulties are endemic to a large variety of government services other than human services. They become especially noticeable in situations that involve multi-problem or "high risk" clients, families, and offenders.

The major aspects of coordination of interest in the needs assessment are comprehensiveness, compatibility, and cooperation (Aiken et al., 1975). Comprehensiveness is "... whether all the necessary resources and services are present and ... available to clients" (p. 6). If absent, then strategies are required to develop and provide resources (e.g., training). The presence of resources does not immediately lead to coordination. Compatibility is also a required element of coordination. It is defined as the "... proper linking and sequencing ..." (p. 8) of resources based upon a system of inter-dependencies (Thompson, 1967). The linkages, themselves, are a function of the nature of inter-dependence and have specific requirements which include formalized norms, planning and information. Lastly, cooperation is included in the definition of coordination. It is defined as "... the quality of relationships between human actors in a delivery system" (p. 8). In our assessment, cooperation has often been mistaken for coordination. In our research, this has included dimensions with both attitudinal and behavioral components, which are also necessary for continued inter-organizational relations in any system of response to children.

In summary, coordination has been treated as the articulation of elements in a social-service delivery system so that comprehensiveness of, compatibility among, and cooperation among elements is *maximized*. But as Aiken & Hage (1968) add, the degree of integration and articulation may vary and hence, so may coordination. It is with this conceptualization that the needs assessment of agencies and an inter-organizational network were developed. Aiken et al. (1975) have found that a number of elements of coordination in a delivery system *require* assessment -- programs, resources, clients, and information. The assessment has a two-fold purpose; first, to identify the level of elements noted; and, second, to identify the *parameters* in which a potential intervention model must "fit" and "operate" effectively given the assets and barriers that are present. The transportability of resources between clients and locations also required assessment especially in rural areas.

IX.1c SERVICE ENVIRONMENT PERSPECTIVE

The major difficulty in service assessments is that the external coordination between agencies and its relationship to client outcomes are practically never assessed, nor evaluated. Research has demonstrated (Lawrence and Lorch, 1967) that as the complexity of a task or even a client increases, the need to integrate activities along with an essential flow of information also increases (Galbraith, 1977). In the case of child sexual abuse, both the problem is complex and the task is complex. This complexity is experienced in terms of victims, multi-problem families, and the task of supportive response through a state and level of collaboration between a number of agencies.

Coordination, in the current assessment, is viewed as a process and as an outcome of concerted decision-making (Warren, Rose & Bergunder, 1974) which involves the examination of a goal or goals which are "common" or collective. Hence, commonness of goals will affect coordination. At this point, cooperation is a subsumed facet within coordination (Aiken et al., 1975), as are operating spheres of consensus (Etzioni, 1975).

In the needs assessment, two levels of coordination required examination in service agencies, one which is administrative (fiscal, personnel, planning and budgeting) and another which is service-related (case coordination, direct services, etc.). The essential point is that the relationships between both can be inverse and what may be beneficial to an agency or agencies may not be the same to clients. The assessment also focused on the state and potential of both within and between agencies. Again, it is important to recognize that there are differences between a state of coordination and the process. The assessment addressed both at each level of analysis.

As noted throughout this assessment child sexual abuse is complex. The complexity is derived from the interaction between agents of organizations and organizations themselves. Responses to victims and families are mediated by a higher level of factors which include goals, mandates, protocols, interdependence and other inter-agency relationships and the state of a "system of response." Helping professionals must assess the "causes and solutions" related to victims within the context of internal and external structures. Those structures have assisted or constrained the determination of both. What is required, then, is a minimally constrained coordinated effort between a number of agency professionals -- a "systemic" mutual effort. Its presence has been examined. However, as most agencies know from experience, this is easier said than done. If obstacles arose at the disclosure or investigative phase, then delivery of services to young victims and families can be obstructed at other stages of an intervention (Meddin and Hanson, 1985). The obstacles may be as simple as communication or as complex as conflicting agency agendas (Perrow, 1965; Scott, 1964). It should be clear then, that the nature of agency relationships are critical elements to the delivery of services. Therefore, an organizational environment perspective is required in a this assessment.

At the level of inter-organizational relationship (IOR) analysis between service agencies, the major research concern has been the problems of coordination and integration (see Goldman et al., 1980). Other concerns have been raised with regard to how agencies can also simultaneously maintain their autonomy (Aldrich, 1978) or maximize service resources (Reiker et al., 1976). Autonomy was a critical factor in this assessment. The mechanisms of coordination may range from loose informal affiliations to more corporate structures (Mulford and Mulford, 1980). In terms of the child sexual abuse situation, relationships between agencies are basically informal. Each set of mechanisms has had a particular cost to both autonomy and coordination.

The relevance of these types of inter-organizational factors to victims and families have been both direct and indirect. At any time, agencies may impede, constrain, or disrupt the continuity or comprehensiveness of service to victims. The direct impact will be on client functioning, familial support, even community supportiveness. With those sorts of relationships between factors and clients, the level of analysis in an assessment has been multi-level.

Systems of inter-organizational relationships (IOR) from pre-investigation through follow-up, at both the organizational and provider level, involve relationships of authority, resources, professional competence, etc., plus the nature of the linkage between agencies (competition, compatibility, even role clarity). In the process of intervention, relationships (interdependence, resource flows, etc.) have determined the nature of coordinated response in terms of structure, process and outcomes. The nature of linkages influence not only performance but the nature of delivery systems management (Attkisson, 1978; Hargreaves, 1977; Morrissey, 1985).

The dimensions of IOR are numerous. However, our concern has been to focus on those which are most relevant to intervention, services and support, more specifically, those variables which will influence the unique but complex problems of victims and their families. Our assessment followed the form of relationships at three levels of analysis -- the dyad (two agencies), set (or cluster of agencies) and network of agencies (IORN). Lastly, the assessment has taken some focus on the characteristics boundary-spanning roles (Aldrich and Heckler, 1977; Boje and Whetten, 1981) that service-providers occupy while delivering services, making referrals, and other client-oriented arrangements.

IX.1d MAJOR ORGANIZATIONAL AND INTER-ORGANIZATIONAL CONCEPTS AND THEIR MEASURES

A number of situational factors (preconditions and barriers) (Hall, 1967) have increasingly been demonstrated as critical factors in the development and sustainment of effective inter-organizational relations between agencies. Of most importance to the current assessment are agency awareness (Klonglan et al., 1976), domain consensus (Schmidt and Kochan, 1972), proximity (Halpert, 1982), localized dependence (Maas, 1979), and size (Van de Ven and Ferry, 1980). Each are necessary preconditions for future relationships.

Agency Awareness operates in a level of hierarchical acquaintance between agencies. Awareness has ranged from notice of existence to director acquaintance to direct personnel interaction between key contact or boundary personnel. Awareness always precedes the recognition of interdependence and, hence, the establishment or further development of IOR's. In many cases, awareness has been defined as the degree to which agency personnel are familiar with the services of other organizations (Van de Ven and Ferry, 1980).

Organizational domains are equatable with service areas. Two issues have been of particular interest during the assessment. The first is similarity and the second is agreement on domain (Schmidt and Kochan, 1977). Consensus has been operationalized as the degree of agreement or disagreement among organizations on the needs of a particular or variety of clientele. Research (Scott, 1987) has demonstrated that it is a necessary, but not always sufficient condition for relationships to exist. However, it does and has affected the quality of service delivery relationships.

The likeness of agencies' domains is referred to as degree to which agencies are similar in funding, staff, clients and services. Domain similarity typically facilitates the formation of relationships. However, some research has shown that it may also increase levels of competition between agencies (Broskowski, 1980). It appears that some optimized level is a necessary condition for integrated services. Although "slack resources" and "level of overlap" in systems resources are essential in our determination of systems' needs, it has the potential of becoming an element of incompatibility, if either are threatened by changes in levels of performance or re-allocation (Kopachevsky, 1983).

Broskowski (1980), among others, has noted that geographical proximity is an extremely facilitative factor in the IOR between service agencies. The difficulty, however, is that information may be rapidly transmitted but clients and professionals are somewhat more difficult to transmit. In the P.E.I. context, proximity has become an especially important variable due to the extreme geographical distribution of clients and personnel, as in most rural situations.

As Hall (1987) notes, "IOR's do not just happen ...; they also occur for reasons (p. 245)." They occur on some base of interaction and this base is an important determinant in the nature of the relationship between service agencies and a system of agencies responding to child sexual abuse. The reasons can range from the procurement of resources to coalition and generating legitimacy (Galaskiewicz, 1985). In addition, these forms of cooperation may originate from either the "inside" or the "outside" (Edstrom, 1984) of the organization. The bases of interaction, in turn, significantly influence the nature of the relationship (Kopachevsky et al., 1986) between agencies.

Of particular concern to the assessment, is the voluntary-involuntary nature of the relationships (Molmar and Rogers, 1979), formalization (Marrett, 1971), exchange (White, 1971; Cook, 1977) and boundary-spanner personalities (Galaskiewicz and Shatin, 1981). In the P.E.I. context, many public and private agency relationships operate on what is termed an informal basis. However, many public agencies have as their base of interaction some formal interactions which at times are informally carried out. Some (Scott, 1988) argue that types of formal interactions are essential to an integrated service delivery network. Others (Halpert, 1981) point out that informal relationships suit organizations in awkward positions and thereby affect their relations with other agencies. Of most critical concern, is that they affect the nature of IOR exchange (White, 1977) in terms of resources. Our problem in a rural context is that unfortunately does not ensure access and quality of response.

Although the previously mentioned bases of interaction are "simple" concepts, they are essential in the assessment of service delivery and critical for the planning of a system of intervention and service. The first, mandatedness, refers to the degree to which relationships are governed by law or regulations (Hall et al., 1978) through legislative or governmental rulings. Mandates do not ensure that service interactions will take place nor do they ensure the quality of the interactions for either the agency or the client. In fact, compliance with mandates can sometimes disrupt effective procedures to assist clients (Halpert, 1981) or even provide conflict (Gardner and Snipe, 1970). Mandates can obviously disrupt client service when, as they usually are, they are associated with the flow of resources.

As we have already noted, relationships may or may not be mandated between agencies. At the same time, varying degrees of formalization may exist in these relationships. Formalization, in this case, has been defined as the degree to which interdependency is given official sanction (Aldrich, 1979).

The resource flows between agencies is essential to any form of interdependence and therefore service delivery. As we have previously noted, resources can take a variety of forms from clients to funds to personnel. In many cases, the exchange of resources may be based on the same resources or on equal resources (Aldrich, 1979). In this sense, resource dependencies can affect the overall patterning of organizations' relationships.

Mulford and Mulford (1986) have identified joint programs as a major form of resources and resource flow between service agencies. In addition, Aiken and Hage (1968) suggest that such programs generate relationships of further scope and depth between organizations.

Director interlocks have been a major area of research in the last 20 years. They refer to placement of officers or directors from a focal agency on the board of directors of other agencies (Pennings, 1980). Interlocks provide access to resources, a means to control organizational environments, and other organizational relationships (Burt, 1983).

The structures of service or potential service networks can be as important as the IOR process and its outcomes for clients and agencies. Structures are means by which interactions are regularized (Aldrich, 1979), which means the degree to which they become predictable and less uncertain. Those aspects of structure which are of most concern to intervention and the delivery of services to victims in Prince Edward Island have been formalization and standardization. Both can enhance delivery, and, as is well known in any administration, either can significantly reduce service applicability to clients' needs and become a barrier to services. Our concern has been with types and levels of both factors between dyads of organizations and inter-agency groups.

Standardization is the degree to which procedures and therefore interaction are routinized (Aldrich, 1979) in determining and delivering services to clients. Whetten and Szwajkowski (1978) have determined that reliable estimates can be determined by a single indicator based upon the routineness or case-by-case interaction between an inventory of network agencies.

We have identified a number of dynamics in the relationships between service agencies. Moreover, a number have been identified as significant components to the delivery of services. Coordination and cooperation are easiest to identify and volumes of research have been written on both (Aiken et al., 1975; Gruber, 1981). Both have been viewed as intermediate outcomes in the delivery of services; the end result is quality of service to victims and families.

The end-actions (results) between agencies are also dependent upon the importance of the action to the focal "agency," the frequency of their contact, communications, agency power and conflict. Klonglan and Paulson (1971) first noted that "... the importance placed on the relationship" was a major factor in the generation and maintenance of organizational relationships. It is also a major predictor (Hall, 1978) of frequency of contact and communication which are prerequisites of a coordinated service.

Frequency of contact between administrators and staff can heighten resource flows (Aldrich, 1979) and is typically correlated with intensity. Both flow and intensity have been shown to be associated with coordination. In the planned intervention system, they were assessed for current levels and "potential" levels.

Communication frequency and form are established essentials in cooperative and coordinated efforts. Van de Ven and Ferry (1980) have established the importance of these variables to IOR and effective outcomes.

Dahl (1957) established power as an essential element of inter-organizational flows. Since that time, it has been examined in numerous ways. Of particular concern in the assessment is the control over resources and compliance which, in effect, determine agency relations and the ultimate centrality of particular agencies. Centrality does affect integration and hence coordination of intervention and services to victims and families.

According to Warren (1967), cooperation is a process in which organizations both pursue and simultaneously tend to retain their autonomy. Cooperation implies that agencies will attempt to modify their actions toward some common area (Mulford, 1984) on a voluntary basis (Maas, 1979). Cooperation can be examined both subjectively and objectively. For our purposes, perceived cooperation provided a sufficient measure of current operating relations but more importantly helped to identify the potential for network intervention changes.

Inter-agency research has long recognized the existence of conflict and its effect on organizational relations (Blake and Mouton, 1964). What is important to the services for clients is the speed and nature of resolving conflict between organizations. Both affect the delivery and outcomes for victims and families.

The current assessment looked for types of resolution that are currently utilized and level of use. Both help in the determination of an intervention strategy and the organizational network requirements needed to maintain cooperation and coordination between agencies in the intervention and service delivery phase.

It has been our intention to examine this "process" or intermediary outcome at both the administrative level and the service level. At the administrative level, inter-agency coordination is treated as one form of IOR interaction. It represents a structural interdependency which will vary in its intensity as its form changes. We have not, however, made the erroneous assumption that the intensity of coordination will increase effectiveness despite its variable effect on efficiency. As Perrow (1979) notes, coordination has costs as well as "presumed benefits."

Coordination operates at two levels -- the perceptual and behavioral. At the administrative level, the bases of coordination are as elementary as the degree to which elements such as clients, funds, and information are shared. Each generates a different intensity of coordination. The degree of coordination present in a "network or system" will be indicated by the extensiveness and intensity of structural relationships.

There are a large number of outcomes that are dependent on the nature of an inter-organizational network. These outcomes, as previously discussed, have effects on the victim, family, organizational and network levels. Outcomes, such as effectiveness are both simple and complex. The current assessment has examined effectiveness in a simple and basically perceptual fashion in the views of other agencies as a system of response. Perceived effectiveness provided an estimate of the potential for a network scheme of intervention. Hall (1977) suggests that coordination be measured by examining how well activities between a focal agency and others, singularly, are coordinated. In this sense, the respondents have defined coordination themselves and evaluated it. This is essential, since choices and arrangements will be chosen on the basis of agency interpretations of others. Several types and forms have been added in this assessment of coordinative effectiveness (Gans and Horton, 1975).

Closely associated with these concepts are an agency's estimates of levels of effectiveness in terms of the relationships that exist between themselves and others. Van de Ven and Ferry (1980) suggest measurement by an organization's estimation of how another agency fulfils its commitments to the focal agency and a network, and, how it estimates productivity, time, effort and satisfaction, and perform its task (Hall, 1977) in relation to a service. Therefore, perceived effectiveness has been operationalized as the degree to which agencies perceive each focal agency in a multi-dimensional evaluative fashion. The dimensions are the organization's evaluation of its commitments, mandate, and judgments whether the relationship is "worthwhile," "productive," and "satisfying."

The compatibility of an organization's goals and operating philosophy is directly associated (Hall, 1977) with an agency's perception of performance and the willingness to develop further linkages. This has provided dyadic as well as network data.

Performance measures of agencies have not been essential to the needs assessment. At present, the intention was to only examine co-variates of current service delivery variables and client outcomes, client referral, contact and comprehensiveness. This analysis provides a better sense of network potential, barriers, and case-management potential in an integrated system of intervention and service delivery.

IX.2 REVIEW OF PROBLEMS AND SYSTEMIC NEEDS

As victims and families move through the various phases of an intervention which include reporting, investigation, court, treatment and support, there may be many people, professionals and agencies involved in their lives. The Coordination of services and service providers is paramount in the healing process of the victim. In addition, as the difficulties in a complaint increase, the probability of difficulties in how "people" and agencies respond also increases. This is a function of the interdependency between service providers and agencies. While various agencies and professionals have been concerned about coordination, in the generic sense, they typically see it at the service-provider level and have noted a lack of cooperation, communication among other components under the general term coordination.

This needs assessment has operated on one standard empirical premise, that before workers can coordinate their behavior between agencies for a particular victim or family outcome, an organizational and inter-organizational structure and process must be in place which creates a work environment, including policies, which identify coordination as a means to accomplish a particular outcome. As organizations create the work environment for work with victims, inter-organizational structures create the environment and need for coordination to accomplish particular jointly defined outcomes. As we review "the system" which is in place, we will identify a number of problems and issues. In essence, we will identify a number of needs of the system that are basic requirements for a coordinated response to the victims of sexual abuse.

Before examining the major coordination difficulties between specific agencies, it is best to examine the systemic difficulties that exist. We have noted previously that the first major area of need in any system of response is interdependence not in terms of "getting" a job done in justice, or therapy, or support or protection, but "getting a unified good job done" for the victim and family. In other words, accomplishing a goal which is integrated into all agencies for the purpose of keeping the victim safe, supported and healing - a basically systemic goal which agencies support and attempt to expedite.

From our observations, as we have noted previously, before a system of response can be modified to meet the needs of children, a "real" system must exist. The present system of response is fragmented, lacks comprehensiveness and has no systemic goals. There may be interdependence in the sense of "getting" a particular agency's goal accomplished, but that interdependence between agencies is first basically "unrecognized" and second it may exist for purposes other than the victim's. In short, there is no real "system of response" to children and families of sexual abuse. What exists is a number of fragmental responses for different purposes. The major requirement in P.E.I. is to develop, establish and maintain a system of adequate response to victims and families. Therefore, in the empirical sense, a system of response does not really exist, only some components of one.

At this point in the review of systemic needs, we must identify the major systemic difficulties, as they have been observed. Then, we can review particular inter-agency relationships (e.g., support group and social services, prosecutor and police agencies, police and social services, etc.) which make up some of the components of a system of response.

Our first focus will be on a number of selected and essential conditions for inter-organizational relationships to exist between two organizations and other components (agencies) in a system. Second, we will review several structural properties of networks of agency relationships and indicate how several factors seem to be affecting the level of coordination that exists between these components.

Let us briefly review what appear as the important "systemic needs" which have been observed from a large variety of sources and aggregated into the identifiable inter-organizational components we will addressed. Every agency we have examined in this needs assessment, has recognized the inadequacy of funding and case overload for interventions and services that respond to victims and families. Despite this situation, there is little evidence of agencies sharing of resources - either budgetary, or personnel, or facilities, or expertise, or even information. Resource sharing is a major element in and precondition of inter-organizational contact for any systemic response. In the same sense, although limited resources are incentives to many agencies to share resources in human services, it is apparent in P.E.I. that the opposite has occurred and agencies - private, volunteer and public are "isolated" and try to survive independently.

In most agencies in Prince Edward Island, this essential building block and precondition for an integrated response is infrequently proposed and virtually never discussed formally. It, on occasion, has appeared informally in discussions between agencies. In most cases, this has not occurred with Public Agencies in other than a cursory way.

To a great extent agencies, both public and private, are still operating in a vacuum of policy towards victims and families. This has been mentioned numerous times about individual agencies during this needs assessment. As a result, this translates into mandates have not been formally modified to respond to children who are sexually abused. The individual agency responses that exist are purely a function of operating goals, if resources permit. Consequently, a systemic goal orientation has been absent and this places little consistency of approach between agencies. This situation is somewhat less true in private agencies and support groups defined agency and inter-agency goals, however, remains absent.

In a systemic sense, the mandates of individual agencies, public as well as private, still remain both restrictive and "too independent." Clear government policy is not present for public agencies. More importantly, private agencies who provide treatment, counselling and support have no formal policies to adapt programs to and participate in as part of a systemic response to children. Hence, agencies have developed very independent specializations which are not shared as a resource in a system, leaving gaps in both intervention, treatment and support as has been noted in other parts of this assessment. As a result, the present response is not comprehensive and unevenly distributed in the province. This is most damaging to children and families in rural areas, where access is also constrained by great distance.

The flow and completeness of communication between agencies, and in some cases within, is relatively minimal and in some cases non-existent. This negates the possibility of any error-correcting function between agencies as service-providers. As discussions were held with agency staff, numerous examples have been offered on how other agencies have caused difficulties for victims and their agency because they had not considered the implications of their decisions. On the other hand, most difficulties were to a great extent unknown to that other agency - "everything's fine with what we are doing, there doesn't seem to be too many major problems." This was also associated with jurisdiction and domain control in agencies from hospitals to courts. In short, the possibility of inter-agency coordination is not feasible until inter-agency problems are recognized, corrected and formal communication structures begin to evolve.

It is apparent in public agencies, especially, that horizontal communication between working peers in different agencies must flow vertically in some cases before they return to the horizontal between agencies. This decreases the effectiveness of responses to children and families, and creates reactive mutual adjustments in agencies due to changes in the victim or family.

As we analyze how inter-agency problems are resolved, we quickly realize that (a) there is no inter-agency system, (b) the communication that exists is fragmented or strictly informal, and (c) there is no mutually recognized pattern of problems or interdependence. Obviously, the coordination of any system of response requires information, there is little or none in a network sense. The question that arises is in our analysis was quite simple - is there a system to adjust? The answer is no! There are in isolated instances informally intense flows of information between service providers in one or two agencies, at the direct service level, less or none at the administrative level. Information flow is minimally serial.

When we examine sexual abuse content in flows of communication. The flow is minimal and has no corrective functions because there are no established joint goals to accomplish. In some cases, the information flow which exists is distorted, especially in private agencies, support groups, and public agencies. In essence, when it comes to the sexual abuse of children, there is no inter-agency network, there is no "system" - simply because agencies are not linked by a specified relationship to accomplish a specified goal - helping children heal, and be safe.

The nature of resource flow on P.E.I. is limited to referrals between several agencies. However, the information flows do not correspond to the centrality of the pattern. Human Services agencies must use information to correct demand, re-direct referrals, and correct resource flow. This is neither formal or informal in the current "system" of response. Second, nature of resource flow does not correspond to the nature of referral, as a resource.

Coordination between agencies involves a number of processes of concerted decision-making or actions by agencies - Social Services, RCMP and others. Workers may attempt to coordinate their behaviors, but inter-organizational coordination is required as a pre-requisite. For example, agencies like Social Services, Mental Health and the RCMP must participate in decision-making with mutual adjustments to one another, only then is service-provider behavior 'coordinateable'. This is absent. In addition, the necessary working levels of cooperation is minimal and the consensus on goals domains and responsibility is also minimal between some agencies and non-existent in many others.

At the agency level, there is not only diverse opinion about child sexual abuse, but a variation in knowledge and types of experience. In some agencies, the level of knowledge is minimal and others it is high and selective. In almost every case, personnel at the level of direct service have much greater knowledge and understanding than at the administrative level. Diverse information and opinion are not conducive to the development of joint problem-solving, planning and service delivery to clients who have been abused. This to some extent is coupled with the lack of a "unified" public voice and advocacy for all children and families. As of a few months ago, this has begun to change. It is an essential precondition for effective agency coordination and its maintenance of that process.

The competing operating philosophies that exist at the inter-agency level are a problem in P.E.I., particularly at the support and therapy level. This interrupts resource flow, referrals and the systemic development for a response to children. Past experience indicates that coordination can still occur at the inter-agency level, as long as, an operating goal and means of a systemic response are mutually acceptable, coupled with some degree of effective resource flow. This has to be a priority area in the development of a system of response.

At present, there seems or at least it is stated by many agencies that there is a lack of resources. Consequently, the flexibility that once existed in programs is unavailable. This is typical at the treatment and support level. Flexibility in services is a function of resources, but also, "how things are currently done." This current block to any coordination is based upon the presumption that there is no flexibility or slack resources in agencies. This is the current perception, but it may be inaccurate. The lack of coordination itself has immense costs and also drains agency resources. Agencies seem to be somewhat unwilling to move into agreements of coordination due to their feeling that internal adjustments may be required to make accommodations to inter-agency requirements for coordinative purposes. Hence, there is a reluctance for more coordination between agencies and a low or non-existent levels of cooperation.

A review of agency interaction indicates that obviously some formal agreements have existed in human service agencies in P.E.I. However, none are of a systemic nature. They have primarily covered contracts for services. Hence, the experience in formal agreements for coordination especially in the systemic sense, is lacking. Likewise, those that do exist are seen by many to have marginal effectiveness. Other agreements are outside the human service area - namely between Social Services and Law Enforcement Agencies covering protocols. Others have pertained to the agencies who report child sexual abuse. One may also note that some government budgetary and evaluation policies have discouraged coordination for the purposes of service and support response for victims and families.

The lack of accountability of agencies both public and private for their services or interventions with victims and families has been noted as a major difficulty. At the systemic level there is the even larger problem - a confusion over who, if anyone, has the responsibility for eventual, at times sequential, intervention outcomes for children who have been sexually abused. This has been one of the major causes in the lack of "accountability."

There is a concern about children who have been sexually abused from many groups - in both public and private agencies. However, there still remains no defined responsibility for what sequentially and systemically happens to a victim and family. In one sense this is an additional reason why there is no real system. Responsibility, if it exists, is with a particular agency during the process of an intervention. However, in most cases there is little defined accountability for negative outcomes as they affect other agencies in the process. Consequently, there is no requirement for any real system of response to exist. We transfer ineffective interventions with victims and families to some other worker or agency.

If an inter-agency accountability exists, then it necessitates varying degrees of coordination, which is then first based upon agency accountability. If none exists, any systemic coordination that occurs is a function of basically "voluntary cooperation" and "voluntary acceptance of accountability" at the informal level between workers in different agencies within Justice, Human Services and Support Agencies.

An essential feature of any inter-agency coordination is the working knowledge and awareness of agencies about the goals and operations of each other. Observations indicate that this is lacking. Sometimes, this deficiency even exists between public agencies. It is most evident between public and private agencies who respond to children and families, in this province. This is distinctly associated with the lack of recognition of interdependence between these agencies.

Discussions among agencies seem to indicate that there may be an awareness of potential interdependence, but little recognition of the actual. In short, there appears to be an isolated hierarchy of awareness. Awareness exists only between those agencies who proceed and follow each other in the process of intervention - e.g., schools and social services, or social services and treatment, etc. and the level of goal awareness is definitely associated with the current lack of service awareness.

As we have examined the linkages and procedures (e.g. referrals, investigation, protocols, etc.) and noted the lack of them between agencies, and even within them, we have also observed that few of those linkages are standardized. The lack of standardization appears to be associated with the fact that many of the components have not been combined or easily combined in the current system. Therefore, any form of coordination by planned agreement or planning has not been very feasible and has not occurred. A major precondition for an inter-agency response will be to increase the compatibility of the many components through internal agency adjustments and more integration of goals between agencies. This will increse the possibility of standardization.

Those components in the system which are not similar in nature, (e.g., child protection mandates and criminal code mandates) require and have lacked coordination by a high degree of mutual adjustment between agencies and intervenors. This is an inter-agency relationship which infrequently exists in the current "system" of response, but is required for systemic effectiveness.

Domain consensus is a critical aspect in the development and maintenance of inter-agency and inter-worker coordination. In the current case, we have to examine two dimensions of particular importance. The first is about the nature of sexual abuse, children's needs and family needs. The second, which is directly connected to our discussion of present levels of accountability, is the level of inter-agency agreement about what the role of that agency is in terms of responding to children and what they provide.

First, there was and to some extent still is considerable disagreement about needs of children who are abused and their relative ranking of importance. This is evident in many agencies starting with reporting agencies through Human Services agencies and Justice. This is very closely coupled to the agency's level of recognition of needs. Another part of this domain includes the geographical areas served, clients and resources that it provides. There is some consensus on these factors, but it at times is low.

The second domain is the level of agreement over roles with children and families. There appears to be an operating level of consensus between agencies over what their roles are as defined by their mandate. Consensus over what is included in the roles of particular agencies is low, especially in terms of how they respond to children. Therefore, actual role definition consensus is also low. It is difficult to have a system of response built around inter-agency coordination if there is no consensus on goals, minimal consensus on agency roles and which agency roles are necessary for systemic response. Past experience indicates that consensus in these domain areas is sometimes achieved after a problem area is clearly defined. The agencies, fourteen of them in Prince Edward Island, may be more capable of understanding their interdependence, and dependencies, what coordination is required, and by whom after they recognize and understand their mutual problems. This needs assessment of victims, families, workers, agencies, and inter-agency networks should start the process of definition and recognition of mutual need, if victims and families are to be responded to in an effective manner - and, what may become a much more efficient manner.

One barrier that currently exists between agencies, both private and public is a perceived threat to their autonomy. Any discussions of inter-agency coordination has brought forth comments which indicate a potential loss of control over the areas of budget, fiscal management and program decisions and the probability they will have greater responsibilities. This was further highlighted, by the fear of numerous professionals in the area - who felt that many forms of coordination would reduce their level of autonomy with victims and families. For example, when people intervene, provide service, or support, then the way they work with a child for family, their approach or policies will require mutual adjustment to different ways of working with clients and a commitment to do so. Any form of coordination between professionals, as well as agencies, will have to address these issues. We should point out though, it is frequently solved by many inter-agency agreements.

A second point is that the current levels of autonomy, in both public and to some degree private agencies here, are associated with the evaluability of outcomes for victims and their families. A system of intervention, such as it currently exists, will not have accountability if there is no suitable evaluation of professionals and outcomes. Neither has been feasible or used. Unless fears of autonomy are addressed and suitable mechanisms are put in place to evaluate outcomes or protect professional autonomy, accountability of role, input and outcome are not be feasible.

The fear of a loss of autonomy also extends to client representation in any form of an intervention. One form of representation is advocacy. It has been mentioned frequently and in many agencies has raised concern. We should note that this issue is slightly more complicated in private agencies, but still frequently remedied.

We should note that the numerous technologies that people use as they respond to children - through investigation, therapy, service delivery, and support are not routine. They require constant adaptation to the client who is a child and standardized procedures are not always applicable nor can they be absolutely exact. Therefore, any system of intervention must insure some degree of autonomous decision-making for people involved in interventions.

One of the major barriers to coordination, especially inter-agency, is the level of perceived effectiveness between agencies. In the current vacuum of evaluation of outcomes for clients and families and to some extent offenders, many agencies are operating more on perception than reliable information, because there is none. Consequently, there will be a reluctance toward the development of any inter-agency coordination based upon joint-responsibility for outcomes. Perceived effectiveness has become associated with this reluctance to coordinate at the administrative and the direct service level. The current perceptions, in general, are mutually low except in a few isolated situations between workers.

The major difficulty that the "system of response" faces now is the fact that the perception of effectiveness and even the competence of personnel is not simply dyadic (between just two agencies) it is a mutual one and involves all agencies.

Perceived effectiveness as a barrier to coordination between agencies and as a component of any network of agencies in this Province also involves a view that agencies will or will not carry out the commitments they agree to or the worthwhileness of time and effort they spend with agencies. Later, in a network phase, the value of mutual adjustment, the evaluation of the productiveness in agreements, and the satisfaction with mutual adjustments will become critical factors in the survival of a system of response. At present, the perception of the first two mentioned by most agencies is moderately low. The outlook for the remaining three is highly uncertain.

Past research in this area of effectiveness has indicated that once this reluctance is removed, then development of successful coordination will also generate a basis for correcting perceptions of effectiveness. However, at any point in time, this level of perceived effectiveness can reduce or eliminate coordination between agencies. Therefore, empirical evaluations of the outcomes and the process of intervention have to be required periodically in a system of response.

Inter-agency contact in this Province is relatively low - Agreements, Board placements, inter-agency committees are, in a general sense, marginal. The systemic experience between agencies is low, all are preconditions for effective systems. It is somewhat better in private agencies. Likewise, the participation has been somewhat limited to staff and not administrators, this has reduced the amount of available administrative experience to a systemic response. Public agency committee experience is frequently perceived, at times, to be ineffective. Therefore, formal contact is minimal to moderate, experience is low and outcomes are only sometimes viewed as satisfactory.

In brief summary, past experience in inter-agency coordination indicates that many of the requirements and preconditions for any systemic coordination required as part of a response to victims and families are either non-existent or lacking. Second, some of the situations that exist require correction by policy and new structures. Third, policies are required to enhance and develop inter-agency cooperation. Fourth, a mutually integrated goal is required for any system of response to be effective. And fifth, a revised perspective on resource flow and sharing is required for an integrated response. Therefore, the system does not require adjustment - an inter-agency system must be developed which addresses the inter-dependencies between numerous agencies that in turn either directly or indirectly affect the positive and negative outcomes for victims and their families.

We have reviewed the systemic needs that are required for a effective response to children and families. Many of the more specific requirements of an inter-agency response will be reviewed in our discussion of dyadic relationships between agencies. But first, we will review our research on the nature and deficiencies of the inter-dependencies that currently exist in the service-provider and agency response to children who have been abused and their families.

IX.3 WORK AND AGENCY INTERDEPENDENCE

In the two previous sections of this report, interdependence has been mentioned frequently in our assessment of the response to victims and families. In brief review, interdependence between professionals and agencies may be of a pooled, sequential/serial, or a reciprocal nature. Most of the work that people and agencies do in response to children and families who have been sexually abused varies from being a blend of two types of interdependence or a complex mixture of three. For example, reporting by school personnel or the authorities may be somewhat pooled but primarily serial. In the case of Social workers and police, especially in the investigation phase, likewise with therapists, support personnel and social workers they are complex mixtures of all three types of interdependence. The more refined the coordinated interdependence is the higher the probability of "positive" outcomes for victims. It has not been mentioned frequently in this assessment, but on occasion, a refined blend of inter-dependencies occurs between selected professionals in the intervention system operating on an informal basis.

The nature of interdependence is a major factor in any form of coordination as a process, and a major factor in the effectiveness of outcomes for children and families. The major attribute of coordination which has been lacking in the current "system" of response is first the reduced nature of operational interdependence between personnel and services, and second the lack of recognized interdependence between the same personnel and services. The complexity of the relationships between the numerous participants at both the work level and the agency level have also contributed to a lack of coordination. One might, while using a "conspiracy theory," feel that the magnitude of coordination required for positive outcomes for victims and families has been subject to avoidance. As we have noted frequently, coordination entails great costs in both work and resources adjustments for agencies.

Those perceived costs can be a barrier to developing coordination.

Agencies and workers have typically approached the problem of coordination, if recognized, as a simple problem. In reality, it is complex, and becomes more complex as the nature and mixes of interdependence increases we attempt to obtain more "positive" and less "negative" outcomes for victims and families while using many agencies in an intervention. At present, our review indicates that when any interdependence has been recognized, it is approached simply at the pooled level and felt by most that a minor form of coordination, is required between workers and agencies - the answer has been protocols. The problem is, as would be expected, they haven't produced the level of coordination that was expected or required, unless individual social workers and police officers have worked "together" despite them. In other words, mutually adjusted to the nature of interdependence between them to the case they were involved in.

Decisions and decision-making has been examined throughout this assessment in every area from the following of protocols, to referrals for service, and prosecution. For example, the decision of a police officer to independently re-interview a victim or a member of a family may generate new trauma, unknown to a social worker who later, re-enters to a different situation and has to make newer, adaptive decisions. The decision by a judge or prosecutor, may extend the delay of a trial, it affects the victim but as well a therapist must react to this new situation in the victim - therapy, case plans, support may require modification. The effectiveness of therapy or cooperation of victim in therapy changes other case plans. The outcome of a decision to act, obviously affects the victim, it also affects in another manner, an intervenor or service provider. In short, we have been examining at the service-provider level, what affects a decision and what effect does the decision have on the victim or family in a direct or indirect manner. We recognize high levels of interdependence between many people who respond to children.

In the previous section on agencies, we have discussed the difficulties, issues to be addressed due to a lack of coordination. We have noted that to a great extent there is no real system of response. There is worker and agency interdependence, but it is basically unrecognized. In this discussion we will focus on, based upon numerous worker and agency observations, the nature and levels of these interdependencies in a summative manner as they affect coordination.

The following diagram identifies the major inter-agency linkages that occur in a case of child sexual abuse. Some victims and families will directly or indirectly encounter each, sometimes sequentially - much of the time simultaneously. Each relationship between an agency has been identified with three boxes identified as P (pooled), S (sequential), and R (reciprocal). After examining the decision and decision-making between each dyad or pair of agencies, they have been rated in their level of each type of interdependence primarily in terms of the work decisions which in turn affect victim "outcomes." Each type has been rated as L (low), M (moderate), and H (high). The essential point to make at this point is that these inter-dependencies change as the nature of the case and the accompanying conditions change. Therefore, these levels will change by 30% to 60% when "high risk" cases appear or crisis-situations arise during the intervention with the victim, family, or the offender.

Two additional points should be made as one follows the inter-dependencies. First, they typically change as the victim and family move through the process of intervention and different agencies; and therefore, the intensities change. Second, the interdependence may return, for example, between the Police and Social Services, if an emergency arises in the situation involving the victim and the offender or between therapy and social services while the victim is in therapy. Obviously, effective information flow is absolutely necessary for monitoring, so that case plans or support strategies can be corrected.

At the agency or inter-agency level, presuming a "network" of response is present, the agency inter-dependencies within themselves and between themselves (e.g., therapy or social services) will closely mirror the relationships identified. However, they to some extent remain at the sequential level when we discuss referrals and more to the reciprocal level as we discuss protocols, joint programming, joint goals, information flows and overall effectiveness are considered. The present system has very little reciprocal and some serial interdependency at this point in time. The situation is due to past experiences and the lack of joint goals which include both the victim and family's objectives during the process of the intervention in terms of content and pace.

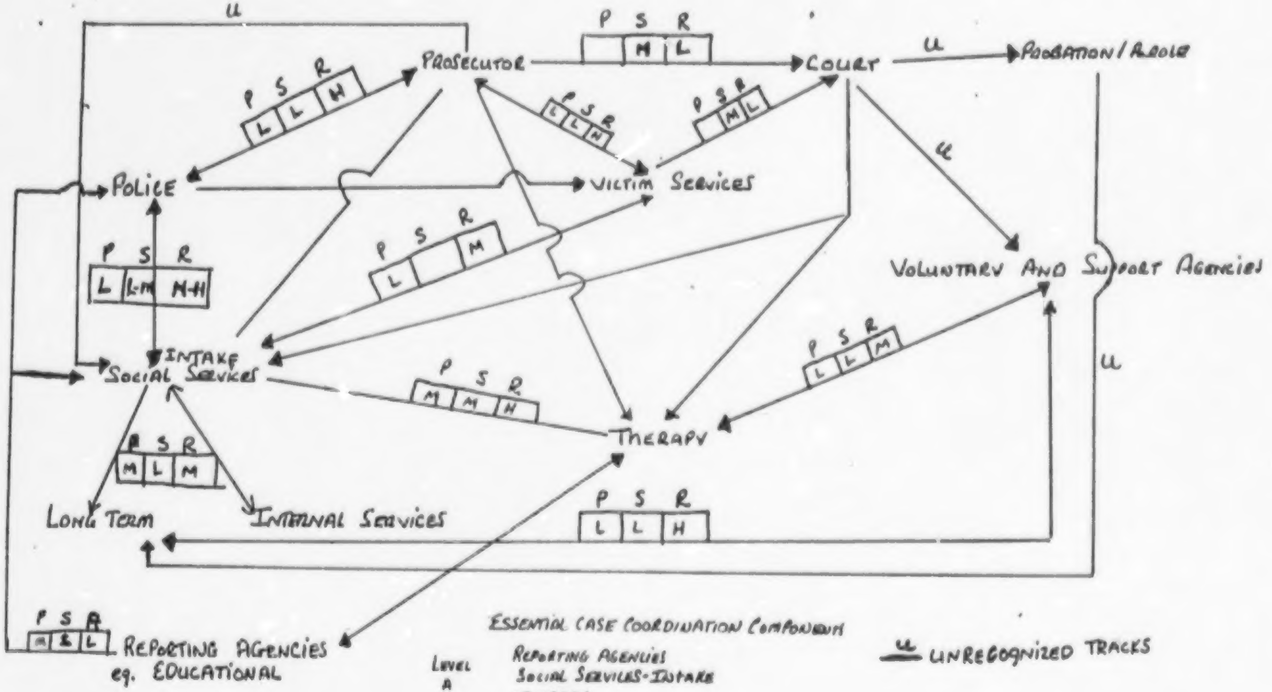
Finally, the intensity of the different types of interdependence helps us to identify two levels of coordination components (levels A and B) which as noted on the bottom of the diagram. Level A are critical elements at the commencement of an intervention and shifts to level B as the intervention moves to other phases. This helps to identify the intensity change between agencies in "average" cases of child abuse, if any do exist. However, as noted, this changes in "high risk" cases. Second, the effective coordination requirements between these agencies vary on the basis of type of interdependence they recognize. Therefore, pooled can be coordinated by standardization of procedures in many of these agencies, plans are required in sequential or serial, and continuous mutual adjustments be workers and agencies are required when the interdependence between them is reciprocal as in investigations, therapy and court. The entire coordination strategy must reflect these needs if it is to be effective for victims and their families. At present, little if any of these coordination strategies exist except for isolated informal ones and their effectiveness has been questioned.

DIAGRAM 9.1

CHILD SEXUAL ABUSE

AGENCY INTERDEPENDENCE

TYPES – POOLED / SEQUENTIAL / RECIPROCAL
COORDINATION OPTIONS – STANDARDIZATION / PLAN / MUTUAL ADJUSTMENT


u
PROSECUTOR
P S R
M L
COURT
u
PROBATION / PAROLE
P S R
L L H
POLICE
P S R
L L H
P S R
M L
u
VICTIM SERVICES
P S R
L L-M M-H
P S R
L M
VOLUNTARY AND SUPPORT AGENCIES
INTAKE
SOCIAL SERVICES
P S R
M M H
P S R
L L M
u
THERAPY
P S R
M L M
LONG TERM
INTERNAL SERVICES
P S R
L L H
P S R
M L L
REPORTING AGENCIES
eg. EDUCATIONAL

ESSENTIAL CASE COORDINATION COMPONENTS

u UNRECOGNIZED TRACKS

LEVEL A
REPORTING AGENCIES
SOCIAL SERVICES-INTAKE
THERAPY
SUPPORT !
PROSECUTOR

LEVEL B.
VICTIM SERVICES
SUPPORT AGENCIES
PROSECUTOR - COURT
SOCIAL SERVICES – LONG TERM
OTHER SOCIAL SERVICES

KOPACHEVSKY (7/30/91)

In summary, any system of response to children must first recognize all these essential inter-dependencies. Second, the system of response will itself create increased interdependency based upon a new set of integrated goals which can be addressed by both plan and mutual adjustments in a number of areas. One of the most essential elements required in the coordination of sexual abuse interventions will be the flow of accurate information along the lines of interdependence between these agencies. More will be discussed on this topic in the next section.

IX.4 SUMMARY OF NEEDS IN AGENCY RELATIONSHIPS

IX.4a Protocols: Reporting Sexual Abuse

The Department of Social Services and Police receive reports or complaints about child sexual abuse, as required by law, from a wide range of agencies. Although some are better than others, there is a general inconsistency among them. Despite the requirement by law, agencies especially medical, school, community support groups (excluding CSA support agencies), people responsible for vulnerable groups is the community, daycare, church organizations and young offender facilities sometimes neither know nor understand the mandatory requirements. It is essential that the mandatory requirements be first re-written and more fully explained to these agencies by both the Police and the Department of Social Services, preferably both. This will begin to remove, not only the confusion, misunderstanding and frustration of victims, but the people who try to respond to them.

The needs assessment had indicated in several places that despite the mandatory requirement, there is sometimes non-compliance. This, based upon our interviews, is a function of "not wanting to get involved" or protection of people who may be involved. The legal implications must be more fully explained by the Department of Justice with an awareness of confidentiality.

Data has indicated that the "ease of reporting" must be modified by revised procedures. More importantly, the speed of reporting is at times essential to an effective intervention and investigation. And lastly, the information that as reported must become increasingly more standardized and accurate in detail. Our research has indicated that many investigations are started with little information of varying accuracy. Consequently, the validation of complaints and the subsequent investigation is hampered in obtaining "good evidence" and commencing an adequate service and support response to children and families. Likewise, both Social Work and Police agencies must more fully explain their "authority" to conduct investigations to these agencies and what are reasonable expectations of the criminal and protection mandates.

The reporting of child sexual abuse by people involved in treatment, counselling and support should be reviewed by all agencies involved and working policy put in place to provide consistency between what is reported, to whom and by whom.

Both police and Social Services agencies must develop policies with hospitals about waiting facilities, response, examination scheduling and the other areas noted. Likewise, policies with physicians about physical evidence must be developed.

The mutual notification of both the Police agencies and Social Service agencies of complaints they have received has to be increased. The lack of notification decreases the effectiveness of investigations and the speed of response. This is especially required in extra-familial cases, even when the offenses are minor. Our data indicates that even minor offenses can have traumatic effects on children who have been abused. Decisions on these matters require joint information and deferral to expertise and experience.

Lastly, adherence to protocols also appears to be a function of flexibility. The current protocols require more explicitness but not at the cost of flexibility to fit varying situations involving victims, families and reporting personnel. Modifications should be based upon comparative review of protocols on other jurisdictions. Not only in content, but effectiveness. After modifications are in place, they will require (a) adherence, (b) periodic review, and (c) change.

IX.4b INVESTIGATION

Various sources of data have indicated that the understanding of protocols by all parties must increase after they have been revised. This should be coupled with the joint education of police and several workers on the goals of the protocols and their use. Each officer and social worker should be assured of consistency of each other in their use of those protocols. This must be coupled with an effective and timely flow of information.

There have been a large number of difficulties described in the needs assessment that occur in the course of investigations in areas including communication, access, interviewing, the use of interview aids, sensitivity, skills, experience, repetitiveness, lack of comfort in doing child sexual abuse investigations, among other things. Three major requirements appear: (1) the need for planning, cooperation, and mutual adjustment between different members of an investigative team, (2) a more effective flow of information on a regular basis, and (3) a unified message from both participants. This would be enhanced through joint-training.

The distribution of expertise and experience has been identified by the needs assessment. Joint planning and contingency plans are required by both Regional Service Centers and law enforcement agencies whose jurisdictions overlap to insure both the availability of trained and experienced social workers and police, especially in rural areas. This will require modifications to some policies - shifting, transfer and others. This should be coupled with a periodic flow of information on availability, distribution and the like.

The flow of information requires modification in terms of content and how it is communicated about both victims, offenders, and families. The issue of confidentiality is important, but policies can be established to deal with that issue. The information requirements for both police officers and social workers should be part of a formalized, possibly centralized system of communication.

In both agencies, policies are required that assist in decreasing the rates of "unfounded" or "unvalidated" complaints and dealing with denial when there is suspicion that the complaint is valid. Coupled with this issue is the matter of "false allegations" and custody cases. Although problematic, their rates will grow in the future. The point is, despite the fact of a false allegation by a complainant other than the victim, the child is still often victimized.

In any case, social workers and police officers would jointly benefit from a mutually developed protocol for investigations at both the police and social worker level and the administrative level. This will create policies for both that are mutually supportive of two difficult roles in the investigative process. Most importantly, the protocols should have flexibility and respond to children's needs. Numerous models of joint decision-making are available in Canada that are suitable for Prince Edward Island.

IX.4c REFERRALS

In a case of child sexual abuse, there are numerous referrals for services for both victims and families between agencies. Referrals are in essence the connection between agencies for victims and families. In addition, referrals are linkages between agencies. In short, they create a network and to some extent create the demand for service between them and to some degree influence the case loads of service providers, unless those demands are mediated by waiting lists. They influence how much of a service is used in another agency and the demand created for it.

A referral is a decision which has created, an unrecognized interdependency between both agencies, and between service providers, especially if one of the service providers is responsible for the outcome of that referral for service. Likewise, the service provider who is assigned the referral or takes it - should take on part of the responsibility for the outcomes with a victim or a family.

One of the major factors that influence demand in the agency that receives the referral is both the urgency, accuracy and suitability of the referral. Urgency is in terms of the immediacy of need, accuracy is in terms of the presenting difficulties and accompanying information, and suitability in terms of how the service fits the actual client needs.

This raises an important factor in the current scheme of referrals. That is the accuracy of assessment and determination of need by the person who makes the referral. First, we find that there are a number of inaccuracies, sometimes in terms of urgency also. Second, the scheme more frequently operates on the basis of the personality of the person to whom the referral is made rather than the treatment or service they provide. This creates an over and under-utilization of resources, doesn't necessarily mean that best service is used to fit need, and a demand which agencies must find resources to alleviate, if it is a public agency.

This situation is of somewhat less difficulty in private agencies. Social Services, Mental Health and other agencies must first increase the awareness of services, an understanding of service and what are "realistic" expectation in a service. The current situation requires more accuracy in the assessment and urgency of need by means of screening before referral. Schemes for screening should be devised by these agencies and periodically reviewed to determine their effectiveness. A high degree of joint-planning is required in terms of demand and service response. Accompanying referral information, especially in child sexual abuse cases, should become standardized. Again, inter-agency review and planning is required in those areas.

The agencies that respond to sexual abuse cases have to increase their options available to persons who make referrals and ensure access to those options for victims and families, especially in rural areas. This may require some degree of resource sharing in therapy and support services. Planning is also required in the flow of information about the effectiveness of services and to which clients the service may be most suitable. Gaps in service will then be more easily identified. This will aid in the better use and more effective development of services and create some adjustments in delays for services.

Each agency who responds to children and families must mutually recognize the reciprocal difficulties that waiting lists and delayed services typically create for the referring agency. Mutual policies, service agreements and planning will help alleviate some of this difficulty, for some victims and families. In addition, our previous data indicated that the factor of perceived effectiveness will have to become increasingly a function of actual information and the questions of operating philosophies corrected.

As mentioned, there has been over and under utilization of therapy and support services. Many of the reasons for this situation were discussed previously. There is, in any case, an inter-agency need to examine an inventory of resources for treatment and support and determine more effective means of utilization in a more coordinated manner of referral. This can be accomplished by joint-planning based upon a common goal - adequate services for victims and families supplemented by an "information system." An information system should identify referral patterns monthly, service use, cases in treatment, counselling, support, presenting problems, acceptability, waiting periods, treatment status, referral closure, and other characteristics. Mental Health Services or Social Services have systems which may be adapted to such functions with one of the many profile packages that are available.

If computerization is used in referral and the reporting, then a more coordinated scheme may be developed to direct the flow of referrals and create better usage of existing resources.

Referrals are also a major factor in the workloads of Victim Services. In addition, a lack of awareness of Victim Services has affected referrals and its response to victims. A more standardized scheme of referral from Justice agencies, Social Services and Support Services would help alleviate some of these difficulties. A reporting policy should also accompany changes to Victim Services referral relationships. If a general policy is adopted, then standardized information can be given to Victim Services from law enforcement agencies, prosecutor's offices, and the court. This will help correct the lack of information available to this agency for scheduling and a more effective response to victims.

IX.4d FOLLOW-UP OF CLIENTS

Numerous recommendations have been made within each agency with regard to the follow-up on clients for several purposes - to assess the current needs or requirements of a child or the family or to simply find out "how they are doing" and to evaluate interventions. Each agency has to evaluate the effectiveness of their interventions so they can adjust the subsequent actions. The requirement of a systemic intervention is to determine its overall action in terms of both negative and positive outcomes. Therefore, agency and inter-agency evaluation are required. This should be a function of joint determination between agencies.

In addition to evaluation, follow-up should recognize that the effects of sexual abuse are sometimes delayed or they can be very long term. With this in mind, we find that an agency or support group will be in contact with a victim throughout the intervention process, and after. Information on victims should be frequently returned to referral sources, or other intervenors on the status of the victims and family.

Agencies, should, as well, be providing information on the status of the victim at the same time back to therapy, Social Services, Victim Services or even the police to correct case plans or intervention strategies.

Follow-up or even perusal of a referral should not be the sole responsibility of an agency who has made a referral. Frequently, when referrals are made - responsibility and accountability for service and the meeting of the client's needs are lost between agencies. A agency should make certain they pursue other aspects of an intervention strategy (e.g. therapy, or even school performance.) Each service provider has to monitor the client and pursue the client in interventions such as therapy - even if the client is reluctant or uncooperative. The victim is temporarily their responsibility as part of an overall intervention to which they must be accountable as part of that intervention. Consequently, this requires a high degree of inter-agency cooperation as an ongoing part of formal inter-agency agreements and coordination.

IX.4e FLOW OF INFORMATION

Numerous sections of the report have highlighted the different needs for information for the purpose of coordinating and correcting an intervention. Before we discuss it at an inter-agency level, we cannot ignore the victim and family. Obviously, in a coordinated intervention and service delivery plan there should be an adequate volume of information flowing between agencies. At the same time, information is available from agencies themselves. In a coordinated manner this should be made available to the victim and the family to keep them properly informed at all times while not sending them conflicting information, no overloading them with information. An inter-agency mechanism should provide this function through a centralized means.

It has been apparent in our assessment that more information should flow between agencies to maintain accuracy, keep people aware of changing situations, how the therapy is proceeding and when court dates change among other things. But information should also be corrective in nature. It should be communicated to help modify intervention strategies with particular victims and families. It should communicate decreases and increases of outcomes. then intervention can be mutually corrected.

Prosecutors should be communicating with Law Enforcement Agencies about the nature and quality of evidence, changes in access, thoroughness of evidence, etc. Likewise, Social Services should be receiving information from the Prosecutor on changes in court. Social Services should in return provide information on changes in the victim or family, new difficulties. When people are more informed about (a) the status of the victim, and (b) the decisions of others, then service providers will be more capable of mutually adjusting their behavior to the action of others and then respond more effectively to the victim. To expedite the flow of information between many of the these agencies, issues with regard to confidentiality have to be addressed. This will reduce the time required to obtain releases from a victim or a family to communicate pertinent information.

IX.4f DECISION-MAKING

Our observations have recognized the need for input from agencies into the decision-making within other agencies to help inform, devise and carry out the most effective intervention for a child and that family. For example, Social Services can provide information to the Prosecutor about the victim and family. Therapists and Social workers can provide valuable input into a pre-sentence report for an offender. Because that sentence for an offender will also affect the victim's and family's situation. Social Services and Therapists can modify each others decisions on the basis of the information they provide and how that input is "received." What is required are recognized means of giving input into decisions by different service-providers and the use of that input in making decisions. Again, we note that there is a reciprocal affect of many of the decisions that are made in sexual abuse cases, starting with investigations. In fact, in many situations throughout an intervention what is frequently required is joint decision-making between two or more persons responding to children and families. In court for example, the goal is to try and support the victim as best as possible. An intervention model may say, for example, it should be a staff from Victim Services. However, the victim and family have perhaps developed a sincere trust in a support volunteer while providing service to them. What is required is a joint decision between a number of people on what would work best for the child, as opposed to a mandate or defined role. Situations such as these occur frequently in interventions starting with the validation of complaints. What is required are inter-agency agreements that permit and encourage joint decision-making, rather than policies which generate "territorial" conflicts, while forgetting victims.

IX.4g SUMMARY AND CONCLUSIONS

One of the major requirements in any intervention and the delivery of services to a victim and their family is that it be a coordinated process. This helps to insure that the outcomes for the victim are positive and the probability of the victim "falling through the cracks" are decreased, leaving their needs unrecognized and unmet.

Coordination is a means by which we accomplish goals. The question that has been asked throughout this assessment has been whose goals has the present scheme of intervention really met. The data and observations in this assessment indicate to some extent they haven't been the victim's very frequently. In fact, the question arose was anybody's goals actually meet?

This assessment began with the premise that there was a system of intervention with a series of complex components-people, agencies, processes, structures, information flow, and corrective mechanisms. We quickly observed that there was in the empirical sense - no system. In fact, many of the components of a system of response were not present, nor were some of the preconditions for a system of response to children.

We have observed a number of fragmented services with very distinctly, independent goals, many of which did not include responding to children who have been abused. Many agencies really recognized the need to do so. Many agencies had not recognized that they were to varying degrees dependent on each other, not only to fulfill their own mandates but to accomplish something in an effective manner for a child who had been sexually abused. So, the problem was how do a number of very different agencies who are "responsible" for one or two components of an intervention that affect a child become jointly responsible for what they contribute to the overall outcome for a child, as they intervened in their lives. Sheer cooperation, even a high level, can never ensure nor accomplish that, especially with agencies who have multiple purposes, low resources and different goals.

The first requirement, are goals which are integrated into each agencies' goal structure. Second, devise and develop a system which can respond to these goals. The overall goal is meeting the needs of a child who has been sexually abused and their families. Third, devise means by which they can more effectively integrate and coordinate their actions with victims. This requires internal agency changes which we have reviewed and noted, and inter-agency changes. It also requires the building of a system. Not in the sense of devising one and putting it in place, but devising one which evolves from a defined structure shared between agencies with an integrated goal and is simultaneously correctable, modifiable, flexible, accountable, and increasingly effective in meeting the needs of children who have been sexually abused.

The most obvious problem with such a solution is how to manage all these separate components having very different functions with a child even if they were coordinated in their efforts? More importantly, was the problem of maintaining coordination, especially when a child's needs and situation may vary so much. In other words, a variable system input. Could agencies accomplish all this adaptation for every child independently. The obvious conclusion was no. Could agencies resolve the child's problems on their own? Could agencies insure quality of response from themselves and others? Could children, on their own, influence what was happening to them by these agencies?

It became apparent that a type of manager in this inter-agency system of response who represented the client, monitored the quality of input from agencies, ensured access and linking to services, and insured that children equally treated was required. In essence, one who helped to identify their multiple needs, linked them to appropriate option in services and insured those services were delivered adequately. A role of monitoring the child's progress and identifying problems but also could recognize system problems and commence correcting or adjusting the system and the reciprocal behaviors of the many who are involved in it.

In the final sections of the assessment on work and agencies, we have noted that there is a requirement for many people to mutually adjust their behavior while responding to a child. Not for their own benefit, but to best adapt what they mutually do to fit a child's needs. Obviously, numerous decisions have to be made in an intervention and it requires a plan or a strategy which numerous agencies can participate in an attempt to accomplish for the child's best interests. Any plan which requires mutual adjustment requires information, experience and various kinds of knowledge. These qualities, however, are very dispersed between agencies and each person could still be making independent decisions even with a case manager. Coordination problems would evolve and a coordinated scheme of response was not developed or in place.

The solution based upon our observation of numerous inter-dependencies was to focus all the information, experience, and knowledge at one point - a team of decision-makers who best knew their areas of expertise and who could mutually adjust their interventions simultaneously in a plan to fit the needs of the child who had been sexually abused. They could jointly review and modify their actions, share some of their expertise so others could more fully adapt their decisions, feedback information and carry out interdependent actions. They could create an overall plan for an intervention and then a case manager could coordinate its implementation and evaluate its progress.

What would be required if, this case manager and team were to be effective. Our assessment indicates a cooperative base of agencies whose actions could be coordinated and mutually adjusted not in a serial but a reciprocal fashion to fit the needs of a child, irrespective of the child's residence. A system of response which was comprehensive and integrated. The inter-agency response would obviously require resources, the sharing of resources especially in rural areas, some degree of joint planning and programming, formal agreements, a defined system of communication which the team and case manager could use, formal contact, a working degree of consensus on roles and responsibility, mutually accepted goals, joint decision-making, mutual awareness, some degree of standardization in referrals and other procedures, and means of resolving conflict,among other things. It required a real system, one with a structure and a purpose designed for the child who had been sexually abused.

The suggested solution appears simple - a case manager for every child who was sexually abused, a team of decision-makers, based upon and working within a inter-agency system of response, one that was much more effective and efficient than the "response" which is in place. The remaining problem was to identify a model based upon our observations of the needs and the present strengths, weaknesses, and experience that exist in the current components of response. tUsing current agency strengths, the choice is an evolutionary model of intervention which moves to increasing levels of comprehensiveness. More will be presented on this solution in the model of intervention for children who have been sexually abused and their families.

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X INTERVENTION AND SERVICE DELIVERY MODEL

X.1 INTRODUCTION

The needs assessment has identified a number of issues, problems, gaps, and potential directions for future services. The assessment examined the needs of victims and families from various perspectives including the victims themselves, families, offenders and the experience and perception of the various systems providing services, with the ultimate goal of translating this information into a model which can effectively provide for the required needs. This, in and of itself, is no easy task because of the large number of factors. Included are not only the potentially damaging effects of the traumatic experience of abuse and the context in which the abused person and their family may be placed, but also the complex nature of the intervention and the healing process.

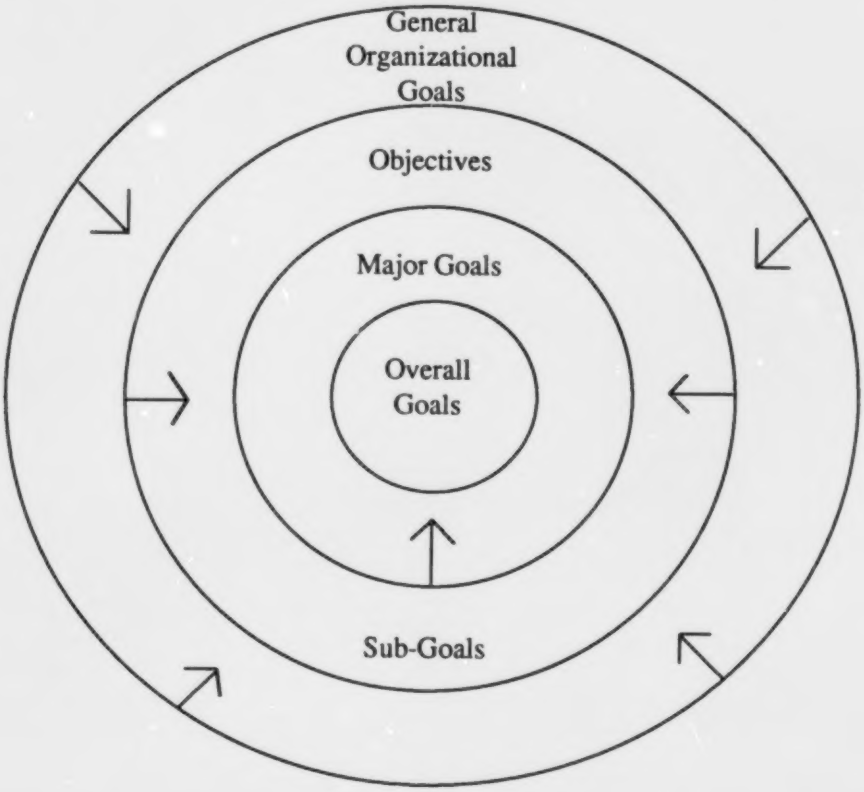
In its simplest sense, the goal of intervention is to stop the abuse, to provide safety for the victim, to allow the victim and family to go through the healing process, and to prevent further victimization. In order for these goals to be reached, a system must be developed which is not only efficient and effective containing the proper components, but is also a system which is continually focused upon the needs of children in relation to his or her family.

The type, nature and degree of needs of the family and victim and the subsequent intervention by the system has been identified as complex because of the nature of the various mandates involved, the intervention into the intimate lives of families and victims, the nature of specialization, the overall need of support, and so on. At the same time, the solutions to these needs, in effect the model, requires considerable levels of inter-agency negotiation and consultation to reduce the complexities and to assure a more effective intervention system. Considerable negotiations will be required between the main agencies involved in the provision of services. As part of a follow-up to a review of the model, it will be suggested that there be developed an ongoing steering committee. This committee will begin negotiating particular, more detailed aspects of the model in relation to its implementation and testing. This proposal for model development will encompass a highly specific focus and direction with the recommendation that the provincial government review the feasibility of the model and begin negotiations with Health and Welfare Canada for a more detailed funding package for the planning,implementation and testing of this model.

The presentation of the model is divided into a number of sections including: (1) philosophy (2) goals, sub-goals and objectives (3) model proposal for testing by the federal government.

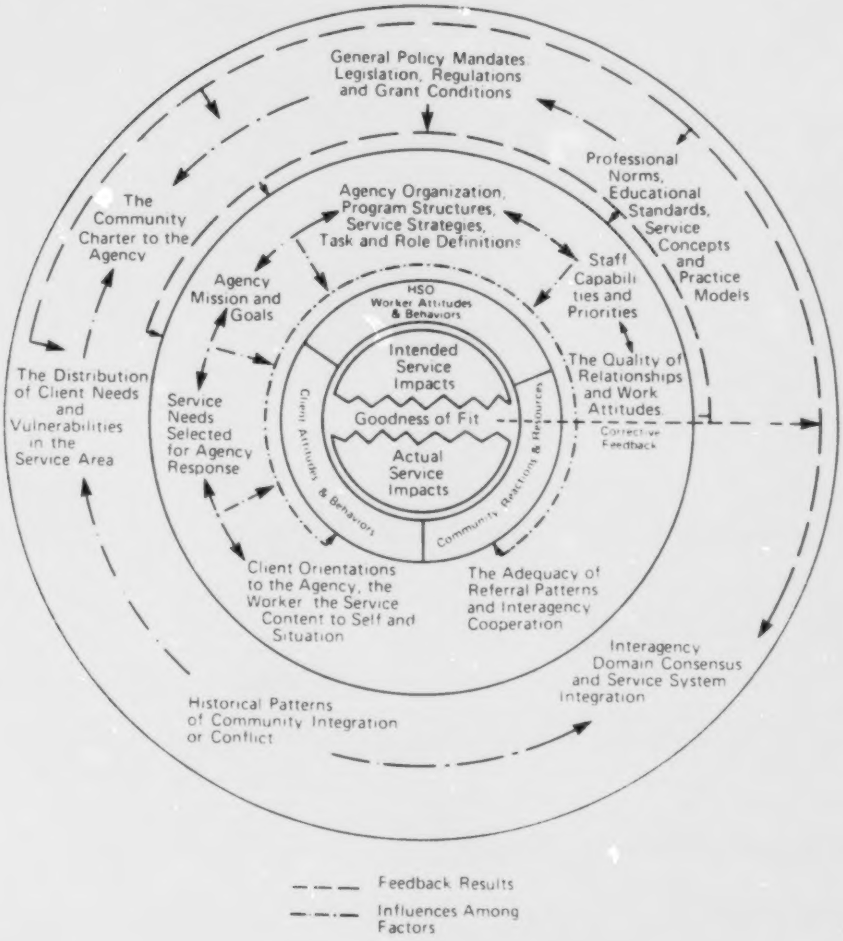
The model places at its center the major purpose or overall goal. In order to achieve that goal, four major goals need to be achieved. For example, to achieve safety, healing and empowerment for victims and families, it is necessary to achieve the goal of a child-centered system which is sensitive and so on. Each of the goals will have a set of sub-goals and objectives which need to be achieved and or put into effect to reach the overall goal of the model. As part of developing new ways of relating and providing programs, there is a need for some overall organizational and inter-organizational changes. Each of these is illustrated below and described in detail further on in this document.

MODEL - Goal Structure



In order to achieve the desired goal for this model, one must take into consideration the impact of a number of factors ranging from worker skills, attitudes, mandates and policies, and inter-agency structures. These factors must be considered from a systemic perspective in that they interact with one another and have a major impact upon the effectiveness of response. Nowhere is this more evident than in the area of child sexual abuse, where so many feelings and attitudes, behaviors and beliefs, skills and resource issues, and mandates and policies exist. The model recognizes the potential for both a positive and a negative impact which may affect services to clients and attempts to intervene in moving an intervention system in a positive direction.

The Various Forces Shaping the Definition of Service Objectives and the Production of Actual Service Impacts.


General Policy Mandates
Legislation, Regulations and Grant Conditions
Professional Norms, Educational Standards, Service Concepts and Practice Models
The Community Charter to the Agency
Agency Organization, Program Structures, Service Strategies, Task and Role Definitions
Agency Mission and Goals
Staff Capabilities and Priorities
HSO Worker Attitudes & Behaviors
Intended Service Impacts
Goodness of Fit
Actual Service Impacts
Client Attitudes & Behaviors
Community Reactions & Resources
The Quality of Relationships and Work Attitudes
Corrective Feedback
The Distribution of Client Needs and Vulnerabilities in the Service Area
Service Needs Selected for Agency Response
Client Orientations to the Agency, the Worker the Service Content to Self and Situation
The Adequacy of Referral Patterns and Interagency Cooperation
Interagency Domain Consensus and Service System Integration
Historical Patterns of Community Integration or Conflict
Feedback Results
Influences Among Factors

X.2 PHILOSOPHY

One of the key areas that needs to be addressed in any model of service delivery is a defined philosophy of intervention. The following statement are the philosophy of the model:

1. The model of intervention should be child centered (focused) in all of its aspects.

2. A child centered system will not harm or re-victimize children. It will be sensitive and take into consideration the needs of children.

3. A child centered system should provide safety for children.

4. The system of intervention needs to be coordinated, cooperative and collaborative. A recognition that a coordinated intervention process minimizes the likelihood of children and their families being negatively affected by the process.

5. Families are the best care givers for their children and should be supported and empowered wherever possible to provide that care. The needs of the family should be responded to and this response should increase the family's ability to support the victim.

6. A child centered system will give children an active voice in the intervention process. It will maximize the right of children and families to be informed and to be involved in decisions which may affect their well being. It will maximize the benefits to children and families above and beyond those of the agencies involved.

7. Intervention should be as unintrusive as possible, while maintaining safety. Protection and safety for children are vital in the healing process, but must be handled with sensitivity and skill to insure that the child is not further victimized.

8. The sexual abuse of children is a crime and is a seriously intrusive and exploitative act. Offenders must be held accountable.

9. The system of intervention needs to be an "open system" characterized by ongoing feedback, self correction and problem solving at all levels.

10. It is important that a child centred system stay as close as possible to the "natural resources" in a child's world in the intervention process.

11. An intervention system must recognize the serious impact of sexual abuse, the need for specialized knowledge and be prepared to commit sufficient time to respond to sexual abuse victims if it is not to contribute to further victimization.

12. A child centered system will provide empowerment for children. Intervention must take into consideration the relative powerlessness of children and should not make interventions which would increase that powerlessness.

13. Sexual abuse is a gender based crime that reflects the social inequalities between males and females.

The following is the overall goal or purpose of the model.

X.3 OVERALL GOAL

To provide an intervention system for child sexual abuse victims and their families within a rural context:

(1) To achieve safety from further sexual abuse and abusive situations

(2) To achieve healing for the effects of the abuse situation

(3) To achieve self-confidence and power and control over their lives to prevent further victimization through an integrated child-centered system of intervention.

X.4 MAJOR GOALS

1. To provide a child-centered and sensitized response to the needs of victims of child sexual abuse and their family which makes the child safe and does not re-victimize.
2. To provide means to adequately respond to the trauma of the abuse experience and to other problems in their lives.
3. To provide a network of support to the child who has been sexually abused to assist in dealing with the formal and informal system of response.
4. To provide means of maximizing children's (and families') sense of control over the intervention in their lives.
5. To provide the victims and families with a system of services which are available, accessible, continuous and accountable.

X.4a GOAL NO. 1 - TO PROVIDE A CHILD-CENTERED RESPONSE WHICH DOES NOT RE-VICTIMIZE

Sub-goals:

(1) To develop means of reducing or eliminating aspects of victimization originating from mandates.

(2) To develop methods of reducing or eliminating victimization as a result of policy, protocols and practices.

(3) To develop methods of reducing or eliminating victimization that is a result

of lack of knowledge and training.

(4) To reduce or eliminate aspects of victimization that are a result of attitudes, sensitivity and personal need.

(5) To develop a method of establishing a more child-centered practice with child sexual abuse cases that is less likely to victimize.

Sub-goal (1) - To develop means of reducing or eliminating victimization coming from mandates

Objectives:

(a) To develop a new child-centered mandate for child sexual abuse cases across agencies.

(b) To identify ways mandates are not child-centered or may be re-victimizing.

(c) To develop means of maximizing the flexibility of existing mandates to be more child-centered.

Sub-goal (2) - To develop methods of reducing or eliminating aspects of re-victimization coming from policies, protocols and practices

Objectives:

(a) To acknowledge revictimization from policy and practice and identify a commitment to end this.

(b) To develop methods of feedback/corrections within and between agencies by utilizing client evaluation, feedback about services, agency interest groups and by establishing a case-review committee.

Sub-goal (3) - To develop methods of reducing or eliminating aspects of victimization that result from lack of knowledge/training

Objectives:

(a) To have agencies and persons recognize the need for knowledge and training:

    (i) to assure that those working with child sexual abuse have the level of specialized knowledge and experience for skillful intervention, and

(ii) to see that all workers dealing with child sexual abuse have sufficient knowledge to assure a sensitized approach through the utilization of formal training opportunities and local community-based training.

Sub-goal (4) - To develop methods to reduce or eliminate aspects of victimization that may come from attitudes, sensitivities, or personal needs

Objectives:

(a) To develop means of increasing worker awareness of the client's experience of intervention through such activities as professional development and training and other training techniques.

(b) To develop means of restricting work with child sexual abuse cases only to those who are motivated or interested.

Sub-goal (5) - To develop methods for establishing a more child-centered practice with child sexual abuse cases that is less likely to revictimize

Objectives:

(a) To identify and correct problems surrounding how child sexual abuse cases are handled concerning revictimization at both an agency and inter-agency level.

(b) To develop a more child-centered policy in responding to child sexual abuse to assure that the voices and experience of children influence these policies.

(c) To identify and develop meaningful training experiences for workers.

(d) To promote public awareness of child sexual abuse:

(i) To increase advocacy

(ii) To enhance community support for children to assure, through the use of protocol, open disclosure and an advisory committee for child sexual abuse

(iii) To increase awareness of child sexual abuse for children in order to develop a preventative/educative component.

X.4b GOAL NO. 2 - TO PROVIDE A MEANS OF ADEQUATE RESPONSE TO THE TRAUMA OF ABUSE IN THE CONTEXT OF THEIR LIVES

Sub-goals:

(1) To identify the effects upon the victim and family.

(2) To provide intervention into these effects.

Sub-goal (1) - To identify the effects on the victim and family

Objectives:

(a) To assure that there is an assessment available to identify impact of abuse and to assure access to services and case planning.

(b) To develop a meaningful plan into specific needs and effects including support, information and treatment services.

Sub-goal (2) - To provide intervention to the effects

Objectives:

(a) To provide a range of treatment options to victims and families to deal with the traumatic effects of the abuse in order to increase self-confidence and improve functioning.

(b) To provide treatment services for parents to:
    i. assist them in dealing with their problems and
    ii. assist in the healing and care of the victim, increase ability of parents to provide necessary support to the child, increase the capacity of parents to understand and deal with the abuse process, and enhance self-care and family health.

X.4c GOAL NO. 3 - TO PROVIDE A NETWORK OF SUPPORT FOR THE CHILD WHO HAS BEEN SEXUALLY ABUSED AND ASSIST IN DEALING WITH THE FORMAL AND INFORMAL SYSTEM OF RESPONSE

Sub-goals

(1) To provide continuous support to families from disclosure through the entire process of intervention.

(2) To provide a support network which is available to assist victims and families.

Sub-goal (1) - To provide continuous support to families from disclosure through the process of intervention

Objectives:

(a) To allow families to feel supported through the process.

(b) To reduce the level of fear and anxiety among victims and families.

(c) To achieve a sense of involvement in the process.

(d) To increase the level of knowledge of processes and proceedings.

(e) To increase the level of satisfaction with the process:

(i) Through the utilization of a continuous contact person.

(ii) Through information on child sexual abuse and other health information for the care of victim and family.

(iii) Through the ability to share feelings, emotions and concerns to a neutral person.

(iv) Through the provision of supervision or a mechanism whereby the needs of victims and families may be clearly represented.

Sub-goal (2) - To provide a support network

Objectives:

(a) To provide a sense of security, involvement and improved self-esteem.

(b) To provide a sense of empowerment and companionship.

(c) To reduce the feeling of isolation and stigmatization.

(d) To receive information to assist in self-care.

(e) To have a long-term support system beyond the intervention of the system through:

(i) Utilization of a community and self-help support group process for victims and families.

(ii) Awareness and availability of such groups.

(iii) Access to such groups.

X.4d GOAL NO. 4 - TO PROVIDE A MEANS OF MAXIMIZING CHILDREN'S AND FAMILIES' SENSE OF CONTROL OVER THE INTERVENTION IN THEIR LIVES

Sub-goals:

(1) To maximize control over what happens in intervention.

(2) To maximize a sense of control over child sexual abuse policy.

(3) To maximize a sense of control over healing.

Sub-goal (1) - To maximize control over what happens in intervention

Objectives:

(a) To provide as much information to the child and family as possible through the development of packages about child sexual abuse and intervention and through a feedback system that provides information about what is happening in the intervention.

(b) To include the child's voice in decision-making and consultation through feedback and advocacy.

(c) To develop a means of amplifying the child's voice through the utilization of an advocate for children and families.

(d) To develop a means of intervention that is at a child's level and pace.

Sub-goal (2) - To maximize the sense of control over child sexual abuse policy

Objectives:

(a) To include children, families, advocates and policy interest groups through such avenues as advisory committee.

Sub-goal (3) - To maximize the sense of control over healing

Objectives:

(a) To create a therapy context based upon the child's sense of control over the process.

(b) To make available a variety of therapeutic modalities based upon the child's needs and choices.

(c) To maximize the child's control over reporting abuse, disclosure and therapy through the development of more flexible protocols for reporting to Social Services.

It is recognized that the goals identified above focus on a number of aspects. These include a system which is sensitive to the needs of victims, is involved in providing information and involvement in the process as well as available support and treatment services to assist in the healing process and to reduce the chance of victimization as the child goes through the system. The ways to achieve these goals are varied and include aspects of awareness-raising, advocacy, skill development and training, resource allocation, and overall organizational issues.

In order for an effective intervention to occur, there must be a number of inter- and intra-organizational structural changes. The following is a description of the goals and objectives in making such changes.

X.4e GOAL NO. 5: - TO PROVIDE VICTIMS AND FAMILIES WITH A PROGRAM OF INTERVENTION AND SERVICES WHICH IS AVAILABLE AND ACCESSIBLE TO THE COMMUNITY AND EFFECTIVE IRRESPECTIVE OF WHERE THEY RESIDE IN PRINCE EDWARD ISLAND.

Sub-goals:

(1) Available - Services and interventions which are suitable to the needs of the victims and families with timely and adequate response.

(2) Accessible - Entry-requirements to interventions and services are universal and flexible to meet needs.

(3) Continuous - A continuum of intervention services, support, joint programs and professionals.

(4) Effective - Each component of and the overall intervention are subject to evaluation and correction.

(5) System - All components are integrated within agencies and between agencies in a recognized inter-dependent manner.

(6) Efficient - The most cost-effective use and development of services and interventions.

Overall Objectives:

(a) All services will be available.

(b) There are no constraints to access.

(c) There are no gaps in intervention and service quality.

(d) People and programs are responsible to their respective agencies and the system of intervention.

(e) Interdependence is a recognized goal and functioning part of the process of intervention.

(f) Use of the most efficient means of providing intervention and services through a set of minimum standards for service to children and families.

(g) Services and delivery meet the needs of victims and families in a timely and effective manner.

X.4f Sub-Goal A

Goals 1 through 5

To develop, enact and maintain a system of intervention and service delivery whose components, staff and agencies, form an integrated set of comprehensive components. The components are comprised of the agencies and staff which partake in an intervention and have integrated the goals of the response model into their agencies.

Goal Clarification Statements:

A. integrated - implies that agencies and the intervention activities have incorporated the goals. In addition, the inter-agency response has incorporated the goals, as have professionals in their singular and joint activities and is reflected in their decisions and evaluation of the components of their past and parts of an intervention.

B. system - is comprised of a series of interdependent components who are the agencies that participate in an intervention. The system is comprised of agencies and the parts of their activities that contribute to an intervention and the network of agencies. Interdependence is related to the activities and task of agencies and service providers which are of a pooled, sequential and reciprocal nature.

The necessary components are:

a) Includes those agencies who respond to children who have been sexually abused, namely - law enforcement agencies, Social Services, Mental Health Services, Private Service Agencies, Crown Attorney, Courts, Victim Services, support services, Hospitals, Schools, Probation and Parole agencies.

b) The components which require modification and integration within agencies - are those parts of goal structures which apply to children and families; structural aspects such as procedures, standardization, centralization of decision-making, formalization, specialization (division of labor); resource adaptations in terms of distribution and allocation; planning adaptations in terms of programming and budgeting; process adaptations in those specific to interventions (e.g. investigation, referral and communication; policy adaptations in terms of 'prioritization' and decision-making areas related to children and families; commitment to the goals and consensus on the means of the intervention; consensus and commitment to the inter-agency network requirements; and support for those service-providers and intervenors who are involved in the system of response through supervision, changes in work evaluation and work environments.

c) The necessary components of an inter-organizational network are - the definition and creation of an operating system of response to children and families; the system requires full sanctioning or mandate; the system of agencies will contract for services as a network; the system members and the system of response operate within the guidelines of mutually established inter-agency protocols; it operates on the basis of formalized agreements related to system requirements; the system is required to share resources with component agencies; the network and component agencies contribute. And cooperate with defined schemes of fiscal management and budgeting; the system will collect through a centralized means information about the intervention; the network and agencies will have a defined scheme of liability; the system and its components will jointly develop and share resources, the system components will cooperate in administration coordination; the system and its components will engage in joint planning and programming; the system components will share in personal practices; other system and components will devise effective means of conflict resolution between staff in the network and agencies in the network.

Sub-Goal A.1 [Case manager/system (coordinator-manager)]

To both coordinate and manage the system of response through a team of case managers one case manager for each victim and their family, if both require a moderate to high level of intervention and response. Managers who are responsible to both victims and the intervention team.

Objectives I.

1. That cases are managed on the basis of a Management By Objectives approach. The objectives are to be established with the clients - both victims and families.
2. That cases are managed under the guidelines of the network of agency philosophy, guidelines and goals of the intervention model.
3. The case managers identify with an intervention team existing, in complete and inadequate intervention and service components and modify them in the intervention process.
4. Case managers maintain client access, resources and information on programs and their availability.
5. Case managers will, insure the compatibility of internal and system components through the proper linking and sequencing of intervention components by both plan and by feedback from all components in the intervention.
6. Case managers will try to maintain the cooperation and quality of working relationships between victims and the others involved in the intervention and delivery of services.
7. Case managers will maintain consensus between team members, and no less than minimum standards of service.

II. Case managers manage and monitor network requirements, and intervene in the relationship between network components when necessary for the purpose of obtaining better outcomes for the victim and family.

III. Case Managers will coordinate at three levels - network, agency-service and client-service provider.

Sub-Goal A.2

To manage and coordinate the joint decision and implementation of intervention and service-delivery decisions of team members which has recognized the goals of the victim. This is to be accomplished by the following means in conjunction with team members.

1. The adequate identification of needs.
2. The adequate identification of support requirements.
3. The identification of most suitable alternatives.
4. The above are facilitated by focusing the information flow, decision-making, recognizing accountability, and the review of intervention plans and other means of management by objectives techniques.

Impact Objectives: Sub-goals Al and A2.

Victim

1. monitor and determine the "well-being" of the client on a continuous basis.
2. determine the level of goal attainment during the process of intervention.
3. adequately match needs with services.
4. insure speed of the intervention.
5. maximize the victim's safety and control.
6. maximize information flow to the victim, team and individual decision-makers.

System

1. identify gaps in services and delivery
2. maximize information flow and feedback to components
3. provide evaluation of inter-agency response
4. identify response system needs
5. redirect system alternatives.
6. increase flexibility of response system
7. aid in system-development
8. identify changing areas of interdependence.

Sub-goal A3.

To maintain a "centralized" and mutually accessible management information system to aid in case management, case evaluation, intervention decision-making, and system evaluation from the following sources (a) and for the following purposes (b).

a. victim, family, Police, Crown, Victim Services, Child Welfare Services, Social Services, treatment Agencies, Support Agencies, Schools and Probation/Parole.

b. assessment, screening, investigation plan, service plan, treatment plan, service delivery decisions, estimation of progress, responsiveness, service quality, problem identification, costs, and systemic evaluation.

c. The information must be accurate, one assurable, timely, and "comprehensive" form its sources.

X.4g Sub-Goal B which is applicable to goals 1 through 5.

B.1 To implement a continuous means of training for intervenors and service-providers who interact with children that have been sexually abused and their families.

a) Objectives: provide additional work skills
modify attitudes toward sexual abuse and the needs of victims and families
enhance knowledge of the nature of sexual abuse and family dynamics and more readily identify needs.
affect changes in behavior in all the areas of interventions with victims and families

Note: Specific skills, attitudes and knowledge have been detailed in Section VIII. 2 through 5 of the report.

B.2 To implement a continuous means of training and evaluation for case managers. Objective: enhance their abilities and raise their level of effectiveness as case managers for children who have been sexually abused and their families.
To be capable of identifying and integrating a child's goals into a plan for intervention.

B.3 To implement a continuous means of training and evaluation for members of child sexual abuse teams. Objective: enhance their abilities and raise their level of effectiveness as a "team of decision-makers" who are involved in a case of sexual abuse involving a child.

B.4 To implement a continuous means of training and evaluation for agency directors who are part of an inter-agency response system. Objectives: enhance their abilities and raise their level of effectiveness in joint planning, programming, inter-organizational strategies, multi system evaluation, and resource sharing.

Sub-goal B2.a (Training)

To support and train case managers. Support is in terms of equipment, administrative, personnel and financial resources. Training to aid case managers carry out the following objectives:

Objectives:
1. effective and efficient management of team
2. incorporating goals of the victim with an intervention plan
3. intervention planning and coordination
4. intervention modification
5. information collection and retrieval.
6. adequate provide information to victim and family.
7. decision-making skills
8. broker and sequence services
9. advocate for client in services or interventions
10. identify and assess needs
11. span organizational boundaries.
12. assess requirements for team management
13. effectively make referrals to effectively manage and coordinate at the system level of response.

B.2.b To support and train team members of an intervention. Support is both by other team members and the agency to represent. Training to aid team members in joint-decision making, planning and evaluation of interventions by obtaining the following objective.

Objectives:
1. create positive attitude toward victims, team processes and guidelines.
2. use recognized team philosophy (model) to establish the values required in decisions, plans and evaluation of outcomes.
3. utilize the necessary skills for intervention decisions which incorporate different types of expertise.
4. utilize of intervention team policies and procedures.
5. capable of participation and involvement in case review and evaluation.
6. Adequate skills in group processes
    a) problem solving
    b) communication
    c) consensus formation
7. building and maintaining trust and confidence in team members.
8. successful coping with the role conflicts that result form dealing with victim needs, model goals, and the agency mandate they represent.

X.5 MODEL DEVELOPMENT AND IMPLEMENTATION

In order for change to occur, it is necessary to:

(1) To explain the premises and orientation of the new system as far as possible as well as to explain specifications of the operating characteristics

desired under a new system.

(2) Clear ideas about the process of change. This includes the provision for involving those whose participation is essential, in both planning and implementation.

(3) Reasonable expectations regarding time frame and stages.

(4) Identification of indicators for tracking progress.

Change usually occurs within an environment and under conditions necessary to mobilize support for introducing new patterns of thought and behavior. The simple introduction of a change process through executive edict, casual invitation to participate, or externally engineered arrangements have not been viewed as effective. In order for change to occur, there must be the following factors:

(1) Acute and widely shared discontent about existing arrangements and results.

(2) Articulation of a clear and vivid image of a desired future for the organization and for attainment of its mission under new arrangements and procedures.

(3) A shared understanding of operation of first steps that if taken can be expected to set the organization on a course towards realization of a desired new state.

Factor (1) - Acute and widely shared discontent

It would appear from the needs assessment that there are many areas identified that need changing and a sense of dissatisfaction with the current state of affairs in services to victims and families of child sexual abuse. In order to be effective, there must be a focusing of concerns and dissatisfactions, not in a defensive way, but in a positive direction. This is done in recognition that the needs assessment is not meant to be an evaluation of services or an identification of any individual agency or individual who is not doing their job. But, rather a need for the system to become more focused and to direct its energies toward a vision of what it can be.

Factor (2) - Articulation of a clear and vivid image of a desired future for the organization and for attainment of its mission under new arrangements and procedures

In order to be effective, those involved must be able to clearly identify an image of the desired outcome of the change. This new image and vision should provide not only the end result of change but it should provide direction. The needs assessment has certainly identified a number of directional areas, and hopefully the model will identify a clear vision and sense of objectives for a new system of intervention.

It is necessary to focus effort and direction in attempting to address the needs of CSA on P.E.I. One is on a broad systemic level including mandates, issues of integration and so on. These issues are faced by every jurisdiction in the country. It is necessary for the province to focus on these and to identify plans of action. In a sense, P.E.I. could provide a test sight and a prototype for other provinces to address these issues on a broader scale. Another important focus, and the actual purpose of the project funding, is the development of a model of intervention based upon a rural context which is applicable elsewhere. These two activities can be carried out in unison. The broader systemic issues are addressed in some detail in objectives of the model and specific section system conditions. The more specific focus of rural delivery systems and second stage funding is described in more detail in the following section.

Factor 3 - Specifications of concrete first steps

In order for real change to occur, there must be a process developed that will identify those steps that must be taken in order to realize the goal. These steps must be realistic, attainable, and be able to show some reasonable results to continue to provide the level of motivation envisioned and required.

X.5a GETTING STARTED

It is necessary to begin to process the information from the needs assessment and the model suggested. The following are the steps that need to occur:

(1) Disseminate information on needs assessment to government departments through more detailed data sharing, and information sessions.

(2) Establish a steering committee to coordinate and legitimize initial action steps. This committee could be made up of representatives of Government Departments, advisory committee members and consumers.

(3) Review the needs assessment document and develop a work plan focused on:

    a) Broader systemic issues
    b) Rural delivery model for testing

        a) Broader systemic issues:
            i. Identify the main areas which need to be addressed including policies and practices which impact on services to sexually abused children and their families.

b) Roles and relationship between main service providers
c) other

ii. Develop strategies to assure consistent polices and mandates to assure effective and coordinated service response which is child centered and provides a"voice" for the client and a feedback process to the system.

(4) Commence system development.

B) Rural delivery model for testing:

i. Review model suggested from needs assessment
ii. Consult with the main services involved in delivery
iii. Consult with Health and Welfare Canada concerning the model
iv. Develop a more detailed proposal as required and submit to Ottawa for funding.
v. Receive funding and implement model as negotiated, developed and accepted by the steering committee.

MODEL PROPOSAL FOR TESTING

The CSA Needs Assessment identified goals and objectives to be addressed within a provincial system of services. One of the main purposes of the current proposal is to test a model of service delivery to victims and families which is applicable across the country. The proposal described below is offered as a suggested direction with the understanding that further consultation with agencies involved in services and Health and Welfare Canada is required.

PRE-FUNDING PHASE

The initial phase will involve the review of needs assessment and submission of a formal proposal to Health and Welfare Canada. Once funded, the project will be designed to go through three separate stages. The first stage will be considered developmental, second stage implementation, and the third will be completion of the evaluative.

The main premise of the proposal is that in order for a rural model to be effective, it is necessary to maximize resources and to provide some methods to formalize the working networks characterized by informal systems, high staff turnover, few highly trained staff and so on. The question to be asked is what type of inputs will have the greatest impact and chance of success and how should these be structured? It seems most likely that it is not so much the content of the input but, rather, how they are applied and reinforced that will determine their success in a rural context.

The project is proposing that with the input of:

1. Training
2. Coordination
3. Support Systems
4. System feed-back/advocacy
5. Specialist utilization of assessment/treatment services.
6. Special Technologies

Then an effective intervention model for CSA in a rural context can be realized.

The project will propose to not only develop and demonstrate a model of rural delivery, but will also develop resources or modules which will provide a blueprint for developing such programs in other areas.

X.6a PROPOSAL STAGES

PHASE I-DEVELOPMENTAL

This phase of the proposal will be developmental and will take 6 to 8 months. During this phase, there will be three major directions.

The first will be the development of resource packages. These packages will focus on three areas including:

1. Training
2. Support Group Systems
3. Assessment/Treatment Packages

The second focus will be on development of the content and structures of the model. This should include the development of the coordination model, inter-agency service contracts, training of staff, and system planing and development.

The third focus will be on the development and establishment of evaluation criteria and structures.

PHASE II-IMPLEMENTATION

This phase will involve the implementation and testing of the model and will cover a total of 24 months. The model could be implemented in Kings and Queens Counties initially. After 1 year, the model could be expanded to Prince County. This method would have a number of advantages from a management and research perspective. It would allow the model to be developed on a smaller scale and be adjusted and fine tuned before expansion on a provincial basis. The Prince County programs could also serve as a control group during the first year of the implementation of the project in Queens and Kings Counties.

The expansion of the model on a provincial basis not only allows for a wider testing of the model, but also offers some direction for other provinces in the development of policies, procedures and practices to deal with a response to the problem of CSA. The model will use a number of time series and outcome research methods.

PHASE III-EVALUATION

The final stage will be a six month period of research analysis and report completion based upon continuous and summative evaluations.

X.6b RESEARCH COMPONENT

The model should use a combination of an experimental design and a goal-oriented approach toward evaluation. The experimental approach is necessary in order to identify, as much as possible, outcomes which are generalizable to other settings. At the same time, the experimental approach is somewhat limited in the ability to isolate controlled conditions, especially as related to such a multi-system approach to the problem. This may tend to reduce rather complex sets of interactions to simplistic causal patterns. There is also a need to identify the important interactive elements which occur in program delivery in order to achieve certain objectives and goals. The model will identify as clearly as possible the goals and expected outcomes and should utilize the most accurate measurement available. It is interested in not only evaluation outcomes, but also the systemic problems identified in the process of the project and aspects of intervention that did or did not work well.

The model can utilize a number of research designs such as control groups, pre- and post-test methods, times series testing, key-informants interviews, and so on. There needs to be a combination of both quantitative and qualitative methods as well as the utilization of client and worker feedback methods for effective evaluation. Many of the resources developed in the needs assessment phase may be helpful in measurement and design. In addition, there are a number of assessment instruments which have been developed in other areas such as are contained in the work of Wolfe & Gentile (1990). These should be considered in order to assist in the research.

The following section identify more specific issues and direction which should be considered in the more detailed submission to Health and Welfare Canada.

X.6c TRAINING PROPOSAL

TRAINING:

Training is identified throughout the needs assessment as a major need for effective intervention for CSA. The utilization of an informational and educational model is viewed as a means to effect a broad spectrum of important factors which are important in delivery of effective CSA programs. Education and information can impact upon beliefs, feelings, behaviors, skills and resources. In a rural context, the ability to focus on quality and capacity of services offers a greater chance of success than simply focusing upon quantity. In particular, the area of CSA is identified as requiring not only a particular caring sensitized response, but also a degree of specialized knowledge. The training proposal would work under the premise that knowledge is transferable and accessible irrespective of the location of the expertise. As such, the ability of rural settings to respond to the problem of CSA is partially a factor of how that knowledge is disseminated and integrated within the programs offered in those areas, as well as the availability of quality training experiences.

A common problem with the delivery of training programs is to assure that they have the desired impact and that they are continuous and ongoing. This is particularly true in rural areas where there is not the availability of training in the first place. In addition, there is a continuous turnover of staff which results in the loss of expertise. The challenge becomes:

a. What knowledge is needed?
b. How does one get that knowledge in to a rural area?
c. Who gets the training and at what level?
d. How can this knowledge/training be continuous (reinforced and available to new staff)?

Since this project views the availability of this knowledge/training as vital in the success of a rural CSA model, emphasis will be placed upon developing required resource packages, effective information and training processes, and means of providing upgrading and continuous learning to assure the provision of high "quality" service. Continuous learning experiences may include the utilization of formal training packages as well as informal methods such as inter-agency learning through ongoing education groups.

The training will be focused upon several levels including:

1. General awareness and knowledge of CSA.
2. Specialized interview and investigative techniques.
3. Training related to assessment of children, families, and offenders for intervention.

4. Treatment intervention.
5. Other generic skills as required.

The target groups for this training will be:

1) Volunteers/advocates
2) Self-help group leaders
3) Police
4) CFS staff
5) Treatment personnel
6) Court personnel (crown, judges, victim services, probation).

The objective of the training program is to increase skills, knowledge and awareness in order to improve overall performance and quality of services. In order to develop the necessary training modules, there needs to be a performance effectiveness assessment in key areas. This identifies the knowledge and skills required for persons to perform successfully in their roles. Some of this has already been collected through literature review, interviews with workers, police, therapists and so on. A more detailed analysis of this information would be required in order to develop training packages and to develop effective standards for CSA intervention.

In designing a training program in a rural area, the consideration of a specialist/generalist approach must be taken into consideration. There is a need for specialized training for effective intervention in CSA. It is not possible however, to train everyone to be a specialist. As a result, what most frequently happens is that the expertise resides in one person. This is especially true in a rural area. As such, the training programs need to be geared towards a specialist/generalists model. That is, a few individuals need to be highly trained, with others trained at a level to provide sufficient back-up when the more specialized expertise is not available.

It must be recognized that training is only one strategy in attempting to effect performance. It must be conducted with the understanding that it is not only workers who need to know "how" to do something, but also that managers must model and set the example. There must be incentives and accountability to perform as well as the time authority and resources to do the job. The information collected in the needs assessment is useful in identifying the current situation in regards to training and also the desires for future performance. The training modules are seen as being of great assistance in developing programs in rural areas.

As part of the development of training modules, an evaluation of effectiveness must be prepared. The evaluation must examine two aspects including an evaluation of effectiveness of the training modules which are to be tested and an evaluation of the outcome and results of the training program. In order to evaluate, it will be necessary to collect some pretest and baseline data. Second, the evaluation will help to clarify the specific outcomes desired.

The evaluation may follow a number of avenues including;

1. Reactive evaluation; This is evaluation by identifying the degree to which participants had satisfaction with the content, design and delivery of the training.

2. Learning evaluation; The objective of this evaluation would be to determine the degree to which participants actually learned what was intended and to determine factors which influence learning such as course content, sequence of learning activities, and so on. The evaluation may include testing of information learned by pencil and paper tests or by observational techniques.

3. Behavioral and skill evaluation; The question to be answered is whether workers are using the skills which have been taught. This can be evaluated by determining the outcome desired and collection of data to evaluate this. This can be determined through behavioral observation, interviews or questionnaires.

4. Impact on services; This is difficult to measure based upon the potential impact on services. For example, the ability of volunteers to provide services can have an impact on services both in terms of overall costs and effectiveness and could be measured in dollars. As well, program impact can be measured by client satisfaction as related to impact on attitudes and skills.

X.6d SUPPORT SYSTEM PROPOSAL

The establishment of a system of supportive and support group services to victims and families is a method to provide a number of helpful resources. The need for support both to family and victim is well documented. The ability to utilize natural support systems to assist in a number of areas of need would appear to offer some help in providing intervention, especially as related to rural areas. The focus of the this aspect of the model would be to develop both a support person and resources to assist victims and families when going through the system, as well as developing an ongoing network of resources such as support groups to provide more ongoing long-term support when needed.

One key area which must be addressed is the structure of integration and the definition of "professional" in support and self-help services. The definition and implementation of the roles and functions of each is vital to the successful implementation of a rural model of service delivery. There needs to be an emphasis upon providing as much natural and informal support to victims and families as possible while confining the role of professional assessment and services to those areas which will utilize those services in the most efficient way.

There needs to be an emphasis on providing as much natural and informal support to victims and families and defining the role of professional services whether they be the support or therapeutic assessment and intervention services of Child and Family Services or of assessment and treatment services to assure the most efficient use of resources.

The system of supports could be drawn from or developed by current support systems such as Rape and Sexual Assault Center, Canadian Mental Health Association, Anderson House or other self-help support systems. The model will identify a need for a number of volunteer options from one-to-one support to short and long-term support. The functions and roles of the support services would need to be defined and integrated into the overall system of intervention and should include an emotional support role, informational role, self-care and development role, and an advocacy role.

There are a number of models to consider in designing the support aspect of the model. These include the advocacy program for the mentally handicapped and the Giaretto model which is specific to CSA and utilizes a large component of volunteer and self-help support options.

The objectives would include not only the development and testing of the support system but also the development of a module or blueprint on how to do this.

X.6e COORDINATION PROPOSAL

The coordination and integration of services is one of the key issues which needs to be addressed to assure effective and efficient intervention. The means to provide assistance must involve a number of inter and intra organizational issues. The nature of mandates, service priorities and divergent philosophies often represent a maze of confusion to persons passing through the system with little overall accountability by any one group. Within a rural context, there are factors which can reduce the fragmentation such as informal systems, smallness, interdependence and so on. At the same time, the lack of structures, resource limitations, turnover of staff and lack of specialization leaves the process too often to chance.

The current proposal will focus on the development and implementation of an inter-agency system of response which is coordinated and managed by case managers. The case managers will be responsible to a victim and an intervention team who plan and modify an intervention for a victim and their family using system resources.

An evolutionary model of development will be proposed which through experience and evaluation will move to more levels of comprehensiveness based upon inter-agency planning and programming. Since the current model includes a management information system, it can aid in (a) the development of the System and (b) the evaluation of the model. Data collection in the model is continuous; therefore, standardized measures of coordination and agency attributes can be employed in the management information system in conjunction with process and victim outcomes. This will provide a means of constant measurement of the intervening input - coordination. Standardized structural and process measures can be used to evaluate the inter-agency system in conjunction with expert evaluations.

X.6f FEEDBACK-ADVOCACY

The nature of sexual abuse and its resulting victimization, along with a large complex system of intervention can potentially revictimize. This places the already vulnerable child in a continuing experience of powerlessness. There are many benefits to developing an empowering experience for victims both on a personal growth level and on a broader systemic level. Underlying the philosophy of the model is a need for a child centered system which offers a voice to victims and families. This model will attempt to integrate that philosophy in it's design and structure. Some of the strategies to consider include maximizing control over what happens in intervention, policies and practice reviews,involvement in decision making, information sharing, development of packages about child sexual abuse and intervention, a system of feedback system that explains what is occurring in the intervention, the development of a client advisory committee, or use of advocates for children.

X.6g SPECIALIST UTILIZATION OF ASSESSMENT/TREATMENT

The need for specialized services in a number of areas including child and family services workers and police to crown prosecutors has been identified. One of the key areas in the healing process is the availability of appropriate assessment and treatment services. This is obviously a problem within a rural context and will continue to be a problem. In order to deal with this, there need to be a number of strategies. One area of concern regards resources. This model will attempt to maximize the utilization of these resources through training, development of clear, specific roles and functions for assessment and treatment, the utilization of other resources for those services not necessarily to be carried out by trained therapists. The ability to identify the number and nature of resources as well as the utilization of these resources should be of great benefit to rural services.

The role of assessment must be developed in order to assure a clear definition of problems, needs and concerns. Some models suggest a mental health assessment on each victim. Other models use risk and behavioral indicators in making a direct decision to assess and treat. Both approaches have benefits and risks, from assuring that no one falls through the cracks, to being over intrusive and causing further problems when there is no need to intervene. A rural services delivery model must fall somewhere between the two, while, considering limitations of resources and specialization.

As identified in the section on support systems, the role of professional treatment services must be defined in relation to functions which can be carried out by informal support systems. The project has as it's objective, the development of specific assessment and treatment modules which will assist not only in consistency of intervention, but will maximize the efficient utilization of resources into a more focused, efficient approach.

X.6h USE OF SPECIAL TECHNOLOGIES

The project will focus on utilizing informational technologies to access expert information, to maximize resources and to assist in orientation to system and protocols where appropriate. Availability of expert knowledge is more assessable today than ever. Rural areas are often handicapped by a sense of isolation from up-to-date information. Computer technology can potentially help in a number of areas including:

1. Access to the latest sources of information through communications hook-up.
2. Utilization of expert-based computer technology to assist in assessment and treatment planning
3. Utilization in on-going training and orientation of staff.
4. Offer assistance in protocol and referral patterns

A study by Robert J. MacFadden, PhD. in 1990 tested the effectiveness of a computer-assisted instruction program to train new protection workers in child sexual abuse assessment. The study demonstrated a small, positive and significant effect upon learning. The potential for greater impact on learning was identified if training could be offered within a supportive and ongoing training and supervision context. Impact upon practice was not studied, but was highlighted as a need for further exploration. These as well as other areas of technology could be explored.

The project will propose to develop and test the utilization of this technology in a rural setting.

APPENDIX A

Child Sexual Abuse Needs Assessment

APPENDIX A. 1

Advisory Committee Information

ADVISORY COMMITTEE MEMBERS

Child Sexual Abuse Project

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CHILD SEXUAL ABUSE RESEARCH PROJECT

HEADINGS AND ISSUES

The following are the top ten issues and the statements which relate to them developed by the Advisory Committee at the meeting on February 27, 1991.

TREATMENT:

- no formalized treatment approach
- little or no services available for pre-schoolers
- inadequate resources to provide therapy to child victims of sexual abuse
- lack of specialists to work with children and adults who have been sexually abused
- failure to recognize long term needs of victims
- lack of provincial/regional inventory of mental health services and rapid information about availability
- need for specialized therapists who can do this work
- lack of emphasis on family therapy
- shortage of group work as a therapy modality
- need for treatment to begin immediately after disclosure
- lack of recognition by professionals to provide immediate treatment to victim
- treatment process is not flexible - lack of people to meet individual needs
- little or no treatment for victims or perpetrators
- isolated treatment
- training and the number of helpers is inadequate

COORDINATION:

- lack of multi-disciplinary approach to validation and treatment approach (child welfare vs community approach)
- lack of role clarification between police, Social Services, Victim Services and Crown Prosecutor which affects information flow to victims and families
- no intake model for survivors and offenders - no coordination among agencies
- lack of definition of "what is an expert witness" and social workers evidence not being used in criminal hearings
- lack of collaboration among professionals involved (generally)
- concern about child telling story too many times
- need for role clarification of professionals involved in investigation
- need for coordination of police investigation with Social Services, etc.
- lack of knowledge of progress in therapy given to caregiver
- inconsistency in direction from different agencies/professionals involved (lack of communication)
- lack of communication among police, Social Services, Crown Prosecutor (3-way communication)
- lack of family support person's involvement in the whole process (4-way communication)
- no coordination between parole/probation with Social Services and other agencies
- no interagency response and approach with case management with child sexual abuse issues. No shared decision making.
- lack of coordination within and between systems
- services within treatment are splintered
- lack of coordination on pre-sentence report (i.e. probation officer doesn't contact victim's therapist)
- problems with privacy act/parole - no information to family/victims, etc.
    - privacy of offender vs victims' need to know

INVESTIGATION:

- lack of trained/designated/specialized police officers and child welfare workers
- lack of internal support for police officers and lack of acknowledgement of their need for specialization in sexual abuse investigations
- child welfare worker does not have the opportunity to be present with the Crown Prosecutor and police to discuss the case
- lack of training for child welfare workers and police
- concern about child telling the story too many times
- investigations unrealistically short
- need for role clarification of professionals involved in the whole process
- need for police investigators to have desirable personality
- lack of investigative follow up when child recants
- investigations may be unusually long due to complications
- lack of refinement of interviewing techniques/skills to keep victim exposure to a minimum
- there are problems with the investigation stages:
    - too many interviews
    - too few people trained
    - negative effects on the child and family
    - add trained female investigators
    - videotaping
- the whole system/process is not child centred

SYSTEM IS NOT CHILD CENTRED:

- lack of sensitivity and understanding regarding children as witnesses
- criminal court process is not conducive to the best interest of children - the court is not "child sensitive"
- court system is not child centred
- adversarial process is very difficult for children
- the whole system/process is not child centred

DISCLOSURE:

- children have fears of disclosure
- child may not be protected after disclosure
- disclosure is not viewed as a process
- what will happen if I tell/disclose? Has the child heard what will happen?
- fear of disclosing and not being believed
- child asks "Will I be taken away?"

TRAINING:

- lack of trained/designated/specialized police officers and child welfare workers
- lack of internal support for police officers and lack of acknowledgement of their need for specialization in child sexual abuse investigations
- lack of thorough training for interviewing and validation methods
- child welfare worker does not have the opportunity to be present with the Crown Prosecutor and police to discuss case
- lack of training for child welfare workers and police
- lack of standardized training for all professionals involved in investigation (initial and ongoing training)
- lack of refinement of interviewing techniques/skills to keep victim exposure to a minimum
- lack of interagency training for professionals
- need for management commitment to allow training
- training and the number of helpers is inadequate

EDUCATION:

- lack of comprehensive assault prevention programs at all school levels
- lack of education and awareness of children regarding sexual abuse
- schools resist education about sexual abuse
- lack of public education about the role of child welfare workers
- lack of education about child sexual abuse particularly for high risk groups
- lack of education in pre-school programs
- lack of empathy of professionals regarding stresses on family members
- people don't know what sexual abuse is
- educational planners are overly cautious in providing meaningful programs for children of all ages about sexual abuse (the same applies to the media and the church)

COURT PROCEDURES/PROCESS:

- too many barriers to prosecution
- time lapse between disclosure and court action is too long
- lack of sensitivity and understanding regarding children as witnesses
- adversarial system invariably hurts the victim
- lack of role clarification in the preparation of the child witnesses
- criminal court process is not conducive to the best interest of children
- judges and other judicial system "actors" are not educated about the effects of sexual abuse
- length of time to get cases through the court process
- need for standardized preparation for court for all professionals
- too much confusion, too rushed as prosecution nears
- court system is not child centred
- dealing with "not guilty" decision
- lack of protocol of understanding of "prosecution vs no prosecution"
- adversarial process is very difficult for children
- adversarial judicial system which "yanks" families apart
- fear of the criminal/child protection court process
- delays in the court process
- decision making in terms of prosecution and the implications of going to court need to be looked at
- priorize and give staff time to these cases in court system
- whole system/process is not child centred
- child welfare worker does not have the opportunity to be present with the Crown Prosecutor and police to discuss case
- belief that therapy taints evidence
- lack of definition of "what is an expert witness" and social workers' evidence not being used in criminal hearings
- criminal justice process is not sensitive to the personal nature of sexual abuse

FAMILY SUPPORT:

- lack of support for child/family between stages of the process
- lack of emphasis on preservation of the family (i.e. institutionalizing children)
- concern that the child continues to be a victim (e.g. removed from the home) after disclosure
- lack of knowledge of resources/process for safety concerns of child victim/family of victim
- need for support mechanisms in order to preserve the "sense" of family
- lack of peer support systems for victims, especially adolescents

PROTECTION OF VERY YOUNG/HANDICAPPED CHILDREN:

- difficulty of obtaining evidence from very young or handicapped children
- difficulty of protecting very young children and mentally handicapped

HOW TO ENSURE THE ABUSE HAS STOPPED:

- abuse can continue even after disclosure

ADVISORY COMMITTEE ISSUES

RANK ORDERED

Note: The number in brackets is the mean of the ranked responses.

1 (4.8)	Treatment
2 (5.6)	Coordination
3 (6.1)	Investigation
4 (6.8)	System is not child centred
5 (7.7)	Disclosure
5 (7.7)	Training
6 (8.0)	Education
7 (8.2)	Court procedures/process
8 (9.7)	Family Support
9 (11.1)	Protection of very young/handicapped children
10 (11.4)	How to ensure the abuse has stopped
11 (11.9)	Personal repercussions and treatment issues
12 (12.0)	Societal Views and Issues
13 (12.2)	Protocols
14 (12.6)	Advocacy
15 (12.8)	Negative impact of the system on the victim and family after disclosure
16 (13.5)	Resources (funding)
17 (14.1)	Reporting
18 (14.2)	Rural
19 (16.0)	Standardized Assessments
20 (16.5)	Monitoring/Evaluation System
21 (17.6)	Public exposure of court/media
22 (19.4)	Objectivity of professionals

ADVISORY COMMITTEE

RECOMMENDATIONS FROM DAY LONG MEETING

Disclosure:

1. Education:
    - uniform education in the schools
    - public education particularly to the reporting laws
    - get the information to kids in school in a variety of ways
    - challenge the schools to use what is available
    - educate teachers and principals
    - make schools "disclosure friendly"
    - standard protocol in the schools

2. Find ways to use the person the child trusted enough to disclose to
    - build in a way to support this person right through to court
    - give the child a choice as to the person she would like to go with her through the process
    - build in flexibility for those not comfortable dealing with CSA

3. Advocacy:
    - help non-offending parents be supportive
    - if NOP not supportive, then need outside advocate, preferably a survivor not affiliated with any agency
    - one person in each case to be child's advocate
    - in many cases this could be the mother
    - support for advocate for their support of the child

4. Child centred approach:
    - address what kids need
    - help them be part of decision making process
    - be truthful with them
    - everything revolve around the child

5. Need of the child to be believed
    - especially by the mother

6. Feedback:
   - follow up to the person who reports the abuse

7. Training:
   - education and training for all professionals
   - reduce turnover in agencies
   - training every 6 months and written information available

8. Increased resources:

INVESTIGATION

1. Specialization:
   - more specialized personnel so not dependent on a few people
   - specialization of training:
   - central specialized group for each county
   - police/social worker/doctor on the team plus someone the kids trust
   - two tiers of specialization:
     a. people in the system specialized
     b. people on the edge no need to specialize (i.e. guidance, doctor)
   - interpreter/advocate for the victim who would be supported by the team
   - flexibility of personnel - those who don't want to deal with CSA cases won't have to
   - be careful not to lose what is now working by formalizing the structure
   - case manager to pull it all together is one possibility of how to make it work

2. Better coordination:
   - between CFS and police
   - no delays
   - better communication within and between agencies
   - case meetings between CFS and police

3. Police procedure:
   - better follow through

- less delays
- more attention to timing
- more flexibility
- specialization of training for police officers:
  - need to check back and keep kids informed

4. Information:
   - should be pamphlets etc. available immediately
   - get kids to talk to other kids either individually or as a group

5. Support:
   - for both families and victims
   - help NOP provide support
   - someone else if NOP can't provide this support
   - unrealistic for CFS to provide this support

6. Minimalist approach:
   - make it the least intrusive

THERAPY

1. Early therapy with no contamination of evidence:

2. Formalized criteria for assessment:

3. Need for more therapists:

4. Need for support:
   - self help and support groups
   - more attention to the family
   - ensure strong ongoing support for the child

5. Time:
   - realization that therapy is slow process
   - takes a long time to heal

INTERVENTION

1. Joint training and updates for all professionals
    - integration of agencies and resources
    - more personnel so the needs of those handling CSA cases can be met

2. Preserve sense of family:
    - put in as many resources as needed to do this
    - family break up is the realization of one of the child's biggest fears
    - kids often removed even when they don't want to leave
    - need consultative, collaborative relationship with the family
    - family should be partner in decision making

3. Minimal intervention:
    - make sure the child is safe for now

4. Information:
    - allow anonymous access to information i.e. Helpline
    - more publicity about sexual abuse

COURT

1. Education:
    - for judges particularly

2. Case monitoring:
    - be aware of new decisions, sentences, techniques
    - data bank to keep judges and Crowns unformed

3. Specialization:
    - more specialized prosecutors so all cases are prosecuted equally

- no private sector lawyers to prosecute sexual abuse cases
- general knowledge for all prosecutors and specialization for a couple

4. Court procedures:
   - tape recorded testifying
   - chamber evidence and testimony
   - screen used more
   - less delays
   - more use of expert witnesses
   - how damaging will longer sentences be since they will produce more fighting back by defence lawyers?

APPENDIX A. 2

Childrens' Perspective
and
Advice About Intervention
with
Child Sexual Abuse

Disclosure

1. What would make it easier for kids to tell? (What could adults do? Are they paying enough attention to what kids are trying to tell them?)

- ***Reassurance of safety/belief.***

Tell them that you trust them and believe them and will do anything to help them.

If adults would tell the kids that it's ok and that they don't have to be afraid. Really reassure the child that nothing will happen and it's ok to show their feelings. If they don't tell they will always think they're dirty and they will be too afraid to go out into the world. They have to be reassured that people care and want to help them and if they get that help they'll be able to make it in the world.

Parents should let their kids know that if they tell they will be believed.

- ***Openness with parents.***

Have family meetings where you can talk about problems.

Parents should always be open with kids, encourage them to tell and trust them.

- ***Education for kids.***

It's important to educate kids early about sex. It's important to let kids know what's happening to their bodies. You can't leave responsibility just on the parents.

Kids need education from earliest grades and kindergarten about child sexual abuse.

Kids need to know more about child sexual abuse, learn about it at home, learn about it at school, starting at grade 1.

Guidance counsellors reading books to our class about child sexual abuse to encourage us to tell. I remembered that it helped.

Talk to them when they are young, ie. age 8 on about what is going on - (about sex and teaching about one's body)

My parents are teaching us but others may not be.

Information to kids before they told (about what happens)

More tv shows

Talking to other victims - kids like me going to school.

- ***Education of others.***

parents
People working in the area of sexual abuse should educate parents better about the origins of sexual abuse in children so they can recognize it.

Parent education about child sexual abuse, how it feels for kids.

teachers
Teachers need more education regarding child sexual abuse, it's impact on kids emotions.

Know how difficult it is to learn. Kids should not have to fail a grade.

- ***Need safe sources for disclosure***

Girls would be afraid to talk to adult males.
Talking to other victims - kids like me going to school.

They should tell the police because it would be all over with. The police would protect them and wouldn't let them touch them.

- *?*

Don't think anything could be made easier.

Investigation

2. What would have made it better for you? How could they make it better for other kids?

- It's difficult, and you can't make it easier.

Don't think there's any way of making it easier. It's going to be hard no matter what the investigators do.

Can't think of anyway of making it easier.

Can't think of anything.

Can't think of anything.

Always will be difficult.

- Some control over process.

It helps to let the kid know that if they feel very uncomfortable answering question or aren't ready yet, they don't have to answer.

If I have had a bit more time after the disclosure. I didn't like the questions at all. To give your statement for 2 or 3 hours is too hard, when you've just told about the abuse for the first time.

Social workers and police coming to the kid's home.

- A better more comfortable setting.

A more comfortable setting

No two way glass

Social workers and police coming to the kid's home.

- Female officers

Female police officer

Women police officer to ask questions, same sex officer.

- *Child - sensitive, helpful interviewers.*

  Someone that really knows what they are doing should do the investigation. Someone who can help the child deal with their feelings and who will help them not to be afraid to tell. They need someone to help them get out and be with other people.

  Help to say the exact words when you don't want to say them exactly.

  Make the words they use easier for kids to understand.

Intervention

3. What could have happened during this time to help you more? (How would you change it to make it better for you and other kids?)

- More control

In group home kids should be more involved in daily running of the house. Kids should be able to read the notes the workers put in their file.

The social workers should ask for your opinion more.

Make more decisions for yourself, stop telling you what to do all the time.

Give a little more space, not try so hard to get information.

- Helpful, sensitive, and informed workers.

The police should be a little easier.

To know that people are there to help. It's important to know that it is not healthy to grow up in an unhealthy environment and that people care and want to help.

Social workers and counsellors should be better informed about drugs, alcohol and sexual abuse.

In group homes male workers that give us the creeps shouldn't work there.

Listen better.

Give a little more space, not try so hard to get information.

Workers could have been there more.

- More suitable placements.

Would have been better off in a foster home with no children.

Therapy

4. What would have made it better for you? How could you change it to make it better for other kids?

- Counsellors who really know about sexual abuse.

Have more counsellors available like mine. She seems to be very well educated in her field and knows a lot about sexual abuse. We need more counsellors with training in sexology. Kids that have been sexually abused shouldn't be sent to a counsellor who isn't educated.

It would be nice to have a counsellor who was sexually abused when they were young so they absolutely know how hard it is. Counsellor should know how it feels and know how to help.

Need to know how sexual abuse makes you feel and why you do all the things you do.

Need better counsellors that know about child sexual abuse, alcohol and drug abuse.

- I had good counselling.

Have more counsellors available like mine. She seems to be very well educated in her field and knows a lot about sexual abuse. We need more counsellors with training in sexology. Kids that have been sexually abused shouldn't be sent to a counsellor who isn't educated.

It's good the way it is. Maybe have it start sooner.

Can't change it to make it better.

No ... I had good counselling.

- Child centered themes.

Talk a little slower

Sometimes she used words too long or sophisticated for me to understand.

Don't force them to go if they don't want to go."

- Start sooner.

It's good the way it is. Maybe have it start sooner.

- *More*

  Need more counsellors.

- *With other kids.*

  Talking to another kid about it (with a tv camera turned on .... so that other kids could learn?)

- Use counsellors to educate teachers and kids.

  Educate teachers about the dynamics of child sexual abuse.

  A counsellor coming to classes to tell kids about sexual abuse and how hard it is to be abused.

Court

5. If you could make changes to the whole court process to make it better for you and for other kids, what would you do?

- Heavier sentences for offenders.

Should be heavier sentences.

Perpetrator gets off way too easily. In certain cases perpetrators should be kept in jail for life - it's like murder.

Heavier sentences for perpetrators of sexual abuse.

Kids shouldn't have to worry about sex offenders being out hurting other kids.

Send men to prison for ten years.

- Treatment for offenders.

Offenders should take long-term treatment. Offenders will always resort back to abuse unless they're treated and given heavy surveillance. Prison isn't the whole solution.

Should be castrated, have no more children.

- Change all the time it takes.

The offender shouldn't be able to stall the court process. It's not that helpful because there are too many stall factors for the offender. It is just for the offender to see if they can make the victim crumble before they go to court. It doesn't seem fair that the offender can do that to the victim.

Take immediate action.

Done and over with - no dragging out.

- Procedural changes in court

Closed court
Court should not be open to the public

In a private room with a judge.

Closed courtroom, open only to those who need to be there.

No eye contact

Should have a better screen set up to prevent her from being seen.

Not to have to look at offender.

More breaks on stand.

More breaks on stand.

More tissues

More tissues.

Later in day.

Later in the day for hearing.

Trusted adult.

Victim should have a trusted adult of their choice in the room with them.

- ***Sensitive, fair and well prepared hearing.***

If judge makes a mistake, it's not her fault, shouldn't be punished.

Crown prosecutor to be prepared and to know what they are doing.

Listen more and trust them when they say things.

Advice to Kids

6. What advice would you have for other kids who have had this happen to them? What should they do?

- Tell some... to be safe get it out in open.

Disclosure is important. It's important to tell and get it out in the open. The kid will have some kind of chance in life if they tell and get help.

Find a best friend or someone they can really trust and tell them. Get it out."

They should tell their parents.

They should get help because they're going to feel dirty and ashamed and they are going to hurt until they get it out."

Don't try drugs and alcohol, you just keep wanting it. They should tell their parents if they are being abused.

Tell the police. Tell their parents. Tell someone who will help them and make them feel safe.

Tell, get help.

Don't be scared of what happened to them.

May not always work, but tell until someone believes you - tell!

Kids don't tell unless they know other kids well , talk to them, victims to victims.

Tell them to tell, try to talk to your parents first.

Say no to the perpetrator and tell someone they trust.

- Talk about it a lot to recover, avoid more difficulty.

They should talk a lot. If they have any problems they should tell.

Don't try drugs and alcohol, you just keep wanting it. They should tell their parents if they are being abused.

Talk about the sexual abuse

Warn them about drugs and alcohol.

See a counsellor to help talk about their feelings.

Advice to Helpers

7. What advice would you have for people trying to help kids who have had this happen? What should they do?

- Give kids control .. trust kids' process.

They shouldn't push kids to do anything. They should be given the right to make their own decisions. Kids know what they need. They should keep an open ear for the kids.

Wait for kids to open up. Don't push them. Treat them as if they can trust you and let them talk when they want to.

They shouldn't pressure the kid to tell. Tell them it's ok and they are there for them.

Don't push kids to talk
Let them go at their own pace
Remembering takes a long time.

Say that you don't have to talk about it if you don't want to.

- Sensitivity to child's experience.

Slow down, talk to them at their level, ensure you understand, make them feel comfortable.

Be more sensitive to what kids are going through ... put yourself in kid's shoes.

Be more compassionate; go to their level.

- Provide belief, safety and support.

They should tell them they're going to be safe and nothing is going to happen to them.

They shouldn't pressure the kid to tell. Tell them it's ok and they are there for them.

Don't be an authority figure, be a friend.

Make sure that they make kids know they understand and that they will help.

Believe and make sure they know you believe, be supportive.

- ***Talk openly/give information.***

Be more open to talk about sexual abuse and make sure they understand.

Give information to kids at school.

Anything Else

8.. Is there anything else about all this that you'd like to tell me about? That you feel we should know?

I don't believe it's right that he (the offender) still has his two kids. I think those kids are in an awful high risk. There should be some kind of protection for those kids. My sister can't really protect them.

Children should tell someone if they're being abused.

Court room should be bigger and parking spots should be nearer the court house.

Experience of Interview

9. What's it been like for you to answer these questions today? Do you have any suggestions for how we might talk to other kids so that they can tell about their experiences and feel comfortable?

OK

This is really good. It's most comfortable in your own home. It's good not to go into details about the abuse.

Good questions. They're hard sometimes. Certain questions can trigger off memories.

It's been good.

They have to be willing. They have to want to be all they can be. Kids have to be reassured that it's OK to talk about it. I think it's going to be helpful for kids in the future.

Not bad. It's good to give advice to others who have been abused.

It was OK. No suggestions.

Enjoyed the interview.

Not hard, covered everything, not too personal.

OK ... you've covered almost everything.

It was as good as it could be. A safe comfortable environment helps ... no office.

You did a good job.

APPENDIX A. 3

Adult Survivors' Perspectives
and
Advice on Intervention
with
Sexual Abuse

Disclosure

1. Why do you think children don't disclose their sexual abuse?

- Fear for their safety.

fear - physical safety
not safe to tell
not safe
perpetrators threats
fear
not safe
afraid
fear
threats
fear of being alone with the offender
fear

- Fear of disbelief

fear of rejection
fear they will not be believed
feel no one will believe
no one will believe
fear of not being believed
afraid they would not be believed or protected.

- Fear of consequences

afraid of parents reactions
fear of family break up
fear of family splitting up
want acceptance, fear of losing it
do not want to upset anyone
fear of consequences, esp. if threatened
fear of family split up
fear of consequences
it could break up the family and be punished for it
fear of consequences

- Confusion - not knowing who or how to tell

don't know who to trust
no where to go
think what the adult is doing must be right
don't know who to tell
many messages not to tell
don't know what is right
too little education, people do not know how to respond
too little knowledge about child sexual abuse, confusion on what is abuse
can't say it, want someone to ask them
lack of knowledge about child sexual abuse
poor communication between child and parents
don't know how to explain
told to keep secret
may not know it is wrong
sense that sexual abuse is not something you should talk about
adults don't know enough about child sexual abuse

- Self blame and other emotional pain.

guilt
humiliation
blame selves
think no one cares
fear it is their fault
self blame
feel hurt, painful
feel they are to blame
fear they have done something wrong
feel they are to blame
the father/daughter relationship could have good points too, not just abuse
shame, blame themselves

2. How do children communicate their abuse?

- Withdrawal

used signs and behaviors eg. withdrawal
communicate abuse through drug use, committing suicide, self-destructive behaviors
disclosure through acting out, withdrawal
disclosure through withdrawal, avoid offender, act out
disclosure through changes in personality, withdrawal, acting out
disclose through withdrawal, moodiness, "messages", fear of adult touch
games they play, imaginary friends, actions (abusive, withdrawal) fear of being alone with the offender.

- Acting Out

some may act out, some just blend in
communicate abuse through drug use, committing suicide, self-destructive behaviors
disclose through delinquency, eating disorders, behavioral problems, (violence ,aggression)
disclosure through acting out, withdrawal
disclosure through withdrawal, avoid offender, act out
some children would act out
disclosure through changes in personality, withdrawal, acting out
disclose by acting out

- Play

disclosure through play
show they are abused through play - learned behaviors
communicate abuse through behaviors, attitudes, way they talk and what they talk about, how they play
games they play, imaginary friends, actions (abusive, withdrawal)

- General Behaviours

show they are abused through play - learned behaviors
disclose through behaviors, but adults don't listen until too late
disclose through behavioral "clues"
disclose in ways adults do not see
tried to tell in a lot of ways

- Other

fear of not being believed
taboo subject
may not disclose other ways because of blocking
may or may not show the abuse

3. What would children need in order to be able to disclose their abuse?

- Create an atmosphere of emotional safety

need to initiate the topic to children
people need to be more understanding
need understanding parents or approachable people they can trust
parent to stand behind them
supportive family
age appropriate approach
improve child's self-esteem
positive parental communication
know there is an understanding person around
deal with it at a slow pace so the child can deal with it
parents need to bring it up and tell kids what they can do about it
parents initiate disclosures
be available
no secrets
someone to listen, trust
have a loving, supportive atmosphere
no punishment for her, no blame in or out of the family
encourage parent/child communication
need someone to ask them, so they don't have to tell

- We must be willing to help the children and stop the abuse

need to know someone cares and will keep them safe
let child know you want to help
something will be done to stop it
we must be willing to stop it
help with feelings, don't just report it to authorities
would be more likely to disclose if didn't have to tell authorities
get child out of situation immediately
trusted persons who they believe would keep them safe

- Educate the children

should discuss it in school with groups of kids, and then alone with child who seems bothered by the topic
begin education in grade 2 or 3
better sex education
kids need more education about child sexual abuse
make them aware of normal sexuality
educate children
discuss inappropriate touches, not just feelings
programs and awareness to help children see that they have rights too
more information, schools, TV, etc
not just getting education from home
better education in schools
educate children on who they can tell,parents as well as others.
education about child sexual abuse, not just strangers, family shouldn't touch in a 'bad' way either

- Educate the professionals

educate people who spend time with children - teacher, guidance counsellor
need good counsellors
educate teachers, counsellors, ministers about child sexual abuse
educate the people who work with children on how to pick out child sexual abuse
awareness for child care workers and knowledge about reporting.

- Public education and information

need more public information
societal attitudes must change
educate parents
better education
parents more aware of signs
more information, schools, TV, etc
more education for the public, so all adults can question children
need more education for adults.

- "Survivor" advocates

a "survivor" therapist
a buddy (therapist)
someone who really understands, someone to show then that it is possible to survive.
they could give detailed explanations of what is going on
a need for "advocates" who have been through it before herself

- ***Don't know/Nothing***

  don't know
  don't know anything parents could have done to make it easier
  do not know of anything to make it easier because children are so fearful

- ***Other***

  child must be very strong

Investigation/Intervention

4. What's your perception of the effects that the investigation has on most children? What's it like for children?

- *The investigation process is intrusive*

cornered
poking for information, nor meeting the child's needs
has to see too many people
child is on "trial"
could revictimize the child
adults who want to know everything

- *Creates fear of negative consequences*

worry what will happen
increases fear of getting in trouble with the family
perhaps put in foster homes that are not healthy
risk of negative memory
fear of the disruption of their home

- *Difficult for children to go through*

hard on them
negative
hard to be investigated
hard for the children if they know it will reported to the police
terrifying procedure
offender has choice - guilty or not
most of the information and needs are on an adult level
little understanding - TV, media, more understanding now
police uniforms are scary

- Fear and other negative emotions

feel alone
scared to death, need protection
would be degrading, no one for support
scary and emotional
intimidating
intimidating
can not get their anger out
sometimes it is OK for a child, sometimes it is not if it is not done well, child and family aren't treated sensitively they will feel scared and bad about having trouble talking about the child sexual abuse - feel bad about themselves.
alarming
stressful
want to withdraw and not do it.

- Positive effects

lets them know someone cares and someone will protect them
sometimes it is OK for a child, sometimes it is not if it is not done well, child and family aren't treated sensitively they will feel scared and bad about having trouble talking about the child sexual abuse - feel bad about themselves.

5. What do children need in the time immediately following their disclosure? What would help them them the most? Sources of support?

- More child sensitive/investigative procedures for child.

shouldn't have to see the abuser
abusers should be severely punished
see court room, get information and "aids" - coloring books
not so many people involved
police should not wear uniforms
stream line - child should only have to disclose two times
all systems respond at once - team
take place in a place where the child is comfortable, neutral
team should be well trained
investigation should happen quickly
perhaps should not go to the child first
proper "cautious investigation", not blown out of proportion
use plain cloths police to lessen fear
no need to be part of the real investigation
tape the disclosure, let the child tell the story in their own way and then put the answers in the interview format
get better interview skills, a comfortable setting
do not publish names or clues

- Control over the process

leave investigation until child is ready
listen and do what the child wants
let the child talk when they are ready
sometimes pulled out of the home, is not good, could stop if the child just says "no I will tell"
give them some choices eg. in treatment
power in decision making if old enough

- Advocacy and support from one person

have one particular person they can trust and open up to who will help them through the investigation
support of a caring person
one person (parent) to trust assist and support during the process
a trained professional to act as a "buddy" during the process
an advocate - someone who has been through this herself

- Support from family

parents' support and understanding
parental support
lots of love, family support
family support
support, caring especially parent
parents should listen and believe
to be at home for support
family to believe and care

- Assurance they are not to blame

not their fault and told it will stop
assure them they are not to blame nothing wrong with them
no blame
explain in detail it is not their fault

- Supportive responses

make the child more comfortable and be secure in what they are doing (to make sure the offender will be punished for doing something wrong)
reassurance that they will be OK
need support of parent, social services and police and doctors.
let them know someone cares
be believed
empathy
treated "special" not "different"
be supported and reassured they did the right thing
adults should not over react
support of a caring person
reassure them nothing is wrong
support tenderness
reassurance with knowledge, safety
support
prevent burying of feelings
should be protected

- *Therapy and counselling*

meet other children with similar experiences
go to counselling: make them understand more
play group with other child victims
approached on a level they can understand by a trained child psychologist
psychiatric therapy, hypnosis be made to go even if they do not want to, psychiatrists and nurses are most supportive
trusting counsellor, maybe for years
lot of therapy
professional counselling to help ease their mind

- *Therapy/support for family*

involve non offending parent as much as possible
parents and caregivers need to be given information on how to help the child during this time (what to expect from children)
support for family
counselling for family if needed
family counseling to keep the family together, wrong to break up the family

- *Removal from abuser.*

removal from abuser
abuser be removed from home, man have no choice
child should be removed if parents can't support them
perhaps removal from home if it is not the best place
offender removed
be with non-offending parent so child's life is not disrupted

- *Worker characteristics*

trained professionals
workers need more training
workers should understand dynamics of child sexual abuse for child and family
be chosen for the work based on how sensitive they are

6. In your view, what are the problems/What is harmful for kids about what happens in investigation and intervention?

- Fear of negative consequence related to the investigation process

abuser may harm the child after the investigation
may be threatened
fear that others will think they are lying
perhaps fear they are going to jail, or the offender is going to jail
guilt and fear something else will happen
being put in an unhealthy foster home
putting the abuser out of the home, the child still cares for him and doesn't want any harm to come to him
risk of more negative effects

- Investigation is an intrusive process - revictimizing

pressure of police questioning, difficult to talk to police
feel uncomfortable in the investigation situation, do not have permission to speak
being questioned about if they invited or caused the abuse
victim is revictimized
revictimized by publication of names
revictimized
interrogation because they are made to think like adults.

- Difficulty related to the investigation procedure

poorly trained investigators, unaware of dynamics of sexual abuse
having to talk about it and bringing up buried memories and feelings
having to talk to so many people about the abuse
reliving the experience over and over again
interviewers have to be objective and don't always convey to kids and families that they believe and care about them.

- Disregard of the child and their feelings

making the child talk before they are ready
tend to think all kids react the same way
not getting therapy, or some they do not want
separation of child from a supportive family member
making the child feel they are to blame

- Societal attitude

subtle way society tells kids not to speak
some people believe kids are to blame

Other

dealing with the shame

Court

7. What's your view of the impact of court on most sexually abused children? How well does the legal process/court respond to children? What problems do you see in the court process for sexually abused children?

- Not for children

doesn't respond to children as well as it should
too big for a child
will never work for children, an adult system cannot work for children
not necessarily a safe place for children
intimidates children

- Getting Better

seems to be getting better
has improved

- Negative experience

negative experience
intimidates children

- Blames child

the child is on trial
blame the child
judges are not up to date, still prosecute women and children

- Facing offenders is difficult

terrifying to go up against family members in court
children cannot be equal when they have to look at the offender
hard on kids if offender is there in the room

- Impact of offender's punishment on children

not helpful for children if offender doesn't get punished
children are upset by the lack of consequences for abusers
children are sent back to abusive situations
doesn't respond well to children, offender treated too leniently

8. Do you think that court plays a role in the healing process for sexually abused kids? Why (or why not?) - . What role? Should kids go to court?

- Kids shouldn't go - too harmful/traumatic

shouldn't go to court
maybe some kids are relieved, but it hard on kids, maybe they shouldn't go
can't play a healing role
no healing role, healing comes from within and relations with others
can be too devastating
do not send them to court - harmful
too traumatic
not for children, but perhaps for adults
do not go to court if too young

- Yes .... if

stiffer sentences could be healing for kids
it is important for the child to say what happened
vindication to see the offender is brought to justice
only if the offender gets what he deserves
if gains outweigh risks

- Procedural suggestions

counsellors should go on their behalf
shouldn't be cross examined

9. What's your perspective on how Island courts have responded to/handled sexual abuse cases? (court process, sentencing) Do you think this has any impact on children's decision to disclose?

- Sentences are inadequate and don't fit the crime

disappointed, poor sentencing, no use in reporting, he gets off and no one will listen
Island courts behind in sentencing and procedures
sentences don't fit the crime
courts do not realize the severity of the crime
punishment doesn't fit the crime
sentences are too short
not proper sentencing
sentences are not adequate
sentences too lenient compared to the impact on the victim
a lot of offenders get no sentence, too lenient
if a conviction then federal time
don't give strong enough sentences

- Time and delays are problems

courts take great time deliberating
hard to keep up with delays and appeals - a child would give it up
defense has more leeway than the crown, too time consuming and too much damage
aren't fast enough

- Effect on disclosure

kids don't read papers or hear, so no effect,
cases on TV affect how kids feel about disclosure
court process does not affect the child decision to disclose
could affect child's decision to tell

- Evaluation of courts' response

Negative

terrible court response
be more child oriented, young kids can't deal with it
no good for children, maybe teens, adults yes

Positive

improved, more sensitive now
crown does the best they can

- Other

need to have mandatory counselling for guilty offenders
court response affects teens more than children
abuse not being stopped, not properly investigated

10. What's needed in the court process (to solve the problems you've identified)? To make it better for children? How ought courts respond to offenders?

- Address systemic problems

create a new system, this one is not working
court controlled by men, do not really understand sexual abuse
revamp sexual abuse law
defendant seems to have all of the rights
court should be more child orientated
don't loose touch with victims
identify with the emotional impact on the child

- Giving Testimony ... should kids go?

get counsellors to go on their behalf, do not want to hurt relatives
be an alternative to court, just tell their story once
stop abuse without going to court
shouldn't have to testify, or else on a screen
give them the choice
lawyer should stand for child. crown should be able to enter the facts
use the investigation as evidence and testimony

- Making testimony easier for the child.

No child/offender contact
not having offender and child in same courtroom
little contact as possible between child and offender
offender and child not in court room together
not have to appear in front of the abuser

Not open/public
cleared of public in courtroom
private sessions with the judge, not an open court room
court should be closed
identity protected

Screen
shouldn't have to testify, or else on a screen
screens

Taping
taping
video tape

Other

sit in a normal chair, not on the witness stand, discuss the abuse in a normal fashion
supportive person to be there and explain the court process
court held in a normal room

- *Longer sentences*

same number of years in jail as he has wasted in their lives
stiffer sentences
severe fines and sentences to give the messages that sexual abuse is not acceptable
high profile civil litigation to scare abusers
stiff fines
stiffer penalties with treatment
need for justice - retribution to help the child heal

- *Education and training for those who work with kids in court.*

train prosecutors, support staff
judges need more education about child sexual abuse and its effects
educate judges

- *Need counselling*

help for male survivors to prevent abuse and help them
not enough counselling for abusers, jail isn't enough

- *Other*

quicker process
removed from home
children should be given information and counselled for court

Therapy

11. What are the most important things that children require to heal/recover from sexual abuse (eg. role of therapy, time, groups, self-help, support, self-direction, and control)

- 22 of 25 respondents mentioned the need for some kind of therapy and several mentioned that it needs to be "immediate" and "ongoing".

- *Control and time*

kids need therapy, but shouldn't be forced
individual ongoing counselling but allow the child to direct it
need information, eg."Deadly Silence"
self direction
control
kids need to be empowered
set their own pace
someone to talk to when they are ready because we all heal in different ways
time
need time to work it through

- *Groups*

groups
group work to show they are not alone
group work, is positive and helps feelings of isolation
group work would be good to decrease isolation
groups will be helpful at the right age
need to know they aren't alone, groups are good for this
group therapy may be good depending on the child and the abusers relationship to them
teen self-help/support groups
group more helpful as adults
group counselling

- *Relationship of individual and group therapy*

individual therapy until ready for a group
individual and group therapy
more group therapy after initial individual therapy - to see that is didn't just to them
group therapy later
groups and individual
steady or rotation idea (attended so many months) of therapy
individual and group therapy

- Helpful and supportive responses

not left alone too much or they may withdrawal
Love and acceptance from parents and caregivers.
reassurance they will be fine
courage and comfort
encourage them to stay with it
love and acceptance from parents and caregivers
support, love and trust
ongoing support
may not be damaged if supported, didn't have to hide, keep secrets and learned to love their bodies
counselling individualized to the child's needs, reactions
age appropriate therapy
ongoing support
need someone to listen
need someone they can trust and get understanding of what happened and how it has affected them
need help to understand the perpetrator
need a lot of understanding
important to believe them
ongoing support
people to believe
react and be calm for the child

- Who should therapists be.

self-help
a trained professional
self-help with professionals over a long period of time
a "survivor" counsellor

- In relation to the abuser

throw abuser out of home
need to see abuser punished, made to stop - what they did was wrong
no contact with the abuser, until they feel they can do it - confront

- Major therapeutic issues

follow-up
increase self-esteem and confidence
therapy focusing on self-worth
reassured abuse was not their fault
reassurance of no guilt or blame and if it felt good that is OK
shame and guilt are often severe
because of investigation and court and therapy the child is picked on and feels bad
kids may feel guilt if their dads go to jail
taught how to trust again, but still be aware of bad situations
may feel they broke up the family
beware of different developmental stages
told the family will not fall apart because they told, and they are still loved

- Other

got to talk a lot about it
make people understand how it is

Recovery: Adult Survivors

12. What are the most important things that adult survivors require to recover from sexual abuse? What advice would you give to those who work with adult survivors?

- Time and control over their recovery process

Need lots of time. A therapist can give a survivor tools that they can use themselves in the healing.

Someone not to label them, let them tell their story over a lengthy period of time. Need more time, don't react too soon, personality needs time.

Need to see them as a whole person, allow individual to say what they wish. They need control; give suggestions/options but don't decide for them.

For survivors: Writing in a journal; talking to to others. For those who work with: Listen and try to understand, be informed and share the information. Read 'The Courage to Heal'.

They should use 'The Courage to Heal' book and workbook. Reading has helped me a lot. It helps me to feel that what I feel is normal.

- Support understanding and belief from others

The need to really listen and to be 100 % on the side of the survivor. They need empathy.

Counsellors should believe survivors. Gives them support and understanding.

A lot of support, need reassurance. Need to know repeatedly to not to blame themselves and to be assertive.

They need a lot of support, feel not dirty, not to be shamed. They are victims. Support from family/friends.

It's important to be believed. There's still an element with others that survivors are making the abuse up.

Being believed, reassured.

Someone to talk to, safe place, safe people, free from fear of being laughed at - blamed.

Support - family, friends, counselling, professionals. You should believe them, let them talk it all out, encourage them to come to terms with it and confront the issue and abuser.

Support, understanding, love and patience. Listen to everything they have to say, no matter how trivial - it all has to come out - let them cry with comfort.

They need real, honest to goodness support, someone they can call day or night who is not going to say the wrong thing to them.

Lots of loving support from friends and family. Others have to let them know they are wanted and needed.

People need support. They need someone to talk to. They have got to find someone to talk to - to help them find answers. They've got to know that it's not their fault.

Need time to listen and just be there for them.

Let the person talk as much as they want. Be there for support during hard times. Explain it's not their fault. Help them regain their self-esteem.

- Important features of the therapy process

Most important the survivor needs to feel that pain. The therapist has to be able to hear the horror. They need more time. Therapists should not invest too much in the survivors' story, it may change over time due to flashbacks and memories coming. It's not the content that's important, it's the feeling.

Therapists need to help them externalize the pain, through artwork or whatever so they can see it and work on it. It can be done through yoga, dance, beating a pillow, whatever.

Through therapy you have to learn how the abuser acts and see each step of how the abuse occurs. It's not enough just to talk about it.

Counsellors need to be unconditional in their support, listen, allow the person to express their pain, be personable.

Need someone sympathetic, not judge, allow me to progress at own speed. Knowledge - understanding of dysfunctional families and abusive behavior.

Information - books; intensive work - week end retreats; do not just talk - write letters, role play, inner child work.

Need someone to help or something to build up their self-esteem.

It's hell to go through the flashbacks; you have to go through the abuse all over again. Help should be available right away so the survivor can deal with it right away.

Need long term therapy.

Important to have a thorough assessment of the survivors' whole life and of the abuse.

- *Important counsellor characteristics.*

Need to know that they don't know it all and don't need to know it all.

A need for more sensitive people in the profession of counselling, perhaps if I had not been such a strong person - may not have sough another counsellor.

Trained therapists who really understand. Therapists who are survivors themselves.

Specialists in the field.

- *Support and therapy groups.*

Group therapy is most important thing. You have to meet with a counsellor individually first to gain trust.

Need a support group - feel isolated at times. Needs to be not extreme group non threatening views shouldn't be pushed on you, ie. not to hate men. Like AA program: need to allow openness, not radical stance, difference between rape and sexual abuse than need to be treated - dealt with separately.

Support groups.

- *Court changes.*

Right to take offender to trial. Perpetrators should pay/exposed publicly.

The court process is a problem- the whole system has to change. The waiting will turn away a lot of people. The victims can't keep standing by while the abuser keeps appealing.

- ***Personal characteristics***

Courage

Healing starts when you stop abusing yourself (eg. drinking, taking drugs). If you abuse yourself, no one else can help you.

Can't dwell on it, you've got to go on.

Advice to Therapists

13. What advice would you give to therapists/counsellors about how to help abused children? What do they need to know?

- What therapists must know

be up to date on all the latest research about child sexual abuse - effects
know the effects of the abuse and be able to recognize them
be able to provide the treatment needed
know how a child's mind works
more dynamics than just the child sexual abuse, especially if the offender is a family member
be experienced - specialized

- Awareness of vulnerability/pain

know how vulnerable they are
realize they are working with the most scared children of society

- Patience and trust in the child

patience to sit and listen
be patient and understand it is hard to talk
do not be afraid of the child or their pain
eventually the child will be able to talk about their abuse
be given the choice to tell, be informed of what will happen if they talk - be reported to authorities
trust is most important
trust the client

- Provide safety/protection

safety
confidentiality
need to have a feeling of protection - a safe place
make sure they are safe and protected
abuser to court (make sure)

- ***Qualities - be caring, supportive, understanding***

  need to be sensitive, approach them on an accepting level
  be there to show someone cares
  be very supportive
  support them all the time
  understand them
  need to be understanding and supportive, personable
  be sensitive
  believe
  be interested - care
  be there for the child
  care
  listen
  believe them
  actively listen

- ***Relate on children's level***

  need to be in touch with their own child-like vulnerability
  deal with the child as an individual - approached for their own needs
  need to deal with a number of different attitudes
  not actually seeing the whole person
  get to the child's level

- ***What needs to be communicated to children***

  You're not to blame
    remind them not to blame themselves
    make them understand the shame is not theirs
    not a sin that it felt bad to them - normal sexuality
    reassure that it is not their fault
    reassure them they are not guilty or to blame
    it may have felt good - OK
    did the right thing when they told and they should be allowed to feel what ever they feel
    do not blame
    don't react
    let them know they are not to blame
    just talk to them - make them understand it's wrong.

  There is help
    let them know there is help

  They're important
    they are important

Doesn't change them

reassure them that this experience doesn't change them in a negative way

They're good kids

they are "good kids"

- ***Useful therapy modalities***

parents need to be involved in therapy
make tools available for the child to express what they need to, not just talk - paint, clay, etc.
self-help books for the children
whole family should get therapy
use play therapy

- ***Other***

do not say "I know how you feel"

Advice to Children

14. What advice would you give to sexually abused children? What would you like to pass on to them from what you've learned from your experience?

- You're not to blame

done nothing wrong
not your fault
not their fault, it was wrong
anyone can manipulate a five year olds' penis to orgasm
not your fault
not their fault
abuse is a power trip for an adults gratification
not to blame

- You can recover; it doesn't have to control you life, you can be strong.

abuse can be resolved
not the worst thing that could happen in the world, doesn't have to control your life - can get over it
eventually grow into adults and then we can control what we do with our lives, make our own decisions
you feel bad now, the hurt will lesson
don't let the experience control your life
hard battle that is worth it in the end
can get over it, the younger you are the easier it is to get over it
pain will go away
something positive can come from this negative experience
will feel better
recovery will make it go away
never going to happen again
can't dwell on it; you have to go on
"stand, stand like a rock, when courage is gone, stand and be strong, open your eyes, don't let them win, reach out and find the power within" (a song)
other things beside committing suicide, if you kill yourself the abuser wins

- You need to talk about it, deal with it.

let them know they should talk about abuse because it will hurt if they don't, get if off your chest
start working through it as soon as you can
talk about it or it will go on and the pain will get worse
talk about it

- Tell someone, get help.

get help
not worth it to let it keep going on
try to stop it, tell someone
get help
people you can trust, look for them
if you don't get support from one person, go to another
doing something good by telling because family will get help
tell someone as soon as it happens
say no "stop it"
get help, talk to a safe adult who you trust
tell as soon as you suspect wrong doing
report it
tell anyone
do not try to hide it, tell someone
tell, get help

- There is help and people who care.

there is help
people do care
people who care without wanting anything
on your side, boost self-esteem and then they will tell in their own time
ways to be helped
support
reassure others will help take away fear and boost self-esteem
find your own way with help with others

- You're not alone.

not the only ones
happens to others
not alone
don't withdrawal

- Abuse is wrong and it messes you up.

abuse screws up your life later on
child sexual abuse is wrong

- You're OK; you're entitled to your feelings; accept yourself

have the night to grieve
valuable
can learn to like yourself
your OK, loved
OK to feel what you feel

Prevention

15. What do we need to do in order to stop sexual abuse from happening? Why do you think it happens? What needs to be changed?

A. CAUSES:

- The role of social values and practice

porno movies make more sexual abuse
people need to change their values, morals and views on life
men abuse because they have always used their power to exploit women and children, women abuse too but not as often
do not really see kids as people so they get abused
society things sexual abuse is OK
on the Island you learn to trust everyone, there needs to be boundaries or limits
societal attitudes need to change
open communication, especially control and power
if society will not accept this, child sexual abuse will decrease
men think they are superior to women
men lack respect for children and women

- The role of offender's motives

abusers can not cope in an adult world
sick people do it for different reasons
no blanket answers - every abuser is different
poor self-esteem, feel unworthy
poor parenting
ignorance - not aware of what is normal
happens because of normal experimenting, puberty and no boundaries
people need to solve their problems in healthy ways - not alcohol, drugs, especially before they get married
some people do not control their urges
alcoholism is the main factor, more likely to happen, keeps mom from talking
alcohol shouldn't be an excuse

Need for power and control
a "controlling thing" for some people
abuse to get control, don't have anyone to compete with, power over children and have no fear of rejection
not sexual, a power game, perhaps he had no power as a child, tries to get power over children
way to get control
do it to feel loved, express power
abusers need for control, nothing to do with sex - power

- *What's going on in families? What's needed in families?*

moms need to be made more responsible, shouldn't have their kids in an abusive situaltion; be forced to respond and protect their children; kids need someone to step in and change things
touchy subject when it is a family member - father has hurt the child but don't want to hurt them
families need to talk
family dynamics - alcohol, parental problems, cycle
need more respect in families, more communication, need to feel special
parents express affection, appropriately address sexuality
better family communication especially to children about sexual norms
be more openly affectionate
work out family problems, show closeness, teach about sexual abuse and the norms of sexuality
open display of affection
parents need to know how to love their children and show it
parents need to communicate with their children
dysfunctional family cycle, lack of communication

B. NEEDS FOR CHANGE:

- *Public awareness about child sexual abuse*

talk more about child sexual abuse in church, meetings, public forums, etc, reach the public anyway possible
public awareness of effects and damage of child sexual abuse - in media
teaching may prevent potential offenders if they know the damage of it
money for people to work in the field, to go out and educate
education - expose it and people will understand it better
publications and public awareness
teach doctors, teachers and all those working with children about the effects of abuse so they can recognize it.
more public information
social awareness, signs of child sexual abuse
courts can not get rid of the problem, social awareness will do it,
awareness and education
talk about it and deal with it
public education
public education that child sexual abuse is wrong
higher public awareness
need more education on impact, maybe then they would stop
need education in schools, TV, etc.
people who work with children must be aware
bring it out in the open especially church
too much stigma
awareness to help children seek help
react differently to survivors of child sexual abuse, they are not "lepers"

encourage reporting

- *Awareness of abusers, potential factors leading to abuse risk*

not a stranger most of the time
could be the prime minister, not just a scumbag
a child's home life can make them more vulnerable
if there is a new person in town and he is getting around with children, then he has probably left another town for a reason, watch him
listen to signs - gifts, money, taken on trips
circles of abusers on PEI, all know each other

- *Educate kids about child sexual abuse*

teach children well, sexual abuse - at home and in school
need to teach facts of life at any early age - to know difference between sex and sexual abuse; at home and at school
posters for children that explain sexual abuse is in places where children go,
subtle information in films, etc.
teach children about their bodies and sexuality at an early age
school education about sexual abuse, elementary years
advice to parents on how to educate children about sexual abuse at an early age
education on good and bad touches at a preschool level - too late to wait until they're in school
streetproof kids and find out about child sexual abuse, stop it
educate children
tell children they can tell
education of right and wrong
encourage and develop a good sense of self-esteem

- *Educate others*

work out family problems, show closeness, teach about sexual abuse and the norms of sexuality
teach doctors, teachers and all of those working with children about the effects of abuse so they can recognize it
advice to parents on how to educate children about sexual abuse at an early age
real information to parents

- *Legal system response*

take abuse seriously, harsher sentences, a message not to do it
investigate all cases reported to social services, do not hasten to prosecute
large fines
child sexual abuse because they get away with it
change statute of limitations for filing civil suits
prosecution is the only venue you have - only way to bring it to the limelight
punish victim, strict penalties
treat offenders and punish them
offenders need to be charged, treated, do not protect their names
stronger sentences

- *Provide therapy*

counsel offenders, do not just punish them
self-help
trained professional

C. CAN WE STOP IT?

- *Stop the cycle of abuse*

children learn what they live ie. if they live with abuse, then they abuse
abuse because abused themselves
two or three years where there is not any abuse to stop the cycle
cycle of abuse - get help to both victims and offenders
family dynamics - alcohol, parental problems, cycle
dysfunctional family cycle
stop cycle of abuse - counsel abusers, victims and family
perhaps abuse because they were abused

- *Can we stop it?*

can't blame it on anyone in particular, everyone is to blame
hard to say what will stop it
treatment doesn't work because we really don't know why they do it
will never stop it - human nature
no way to stop it - happens everywhere
do not know why it happens

APPENDIX A.4

Families' Perspective
and
Advice About Intervention
with
Child Sexual Abuse

1a. Please indicate anything that was helpful to the victim during the CFS investigation.

- Support to the victim.

Amount of support from everyone at the time - relief of having it out in the open.

The guidance counsellor at her school and
her mothers support were most helpful.

- Respect and sensitivity to victim.

Police and social workers were kind to her.

It was helpful in a sense that it was a better experience than the police investigation. She was treated with a great deal of respect from social worker. There wasn't any pressure on her to talk.

Had some to be present for her during police investigation.

- Relation on victim on there level.

RCMP: Chocolate bar, ride in elevator.

A journal that social services got her to keep.

Social worker helped daughter by getting her to draw and making it into a game.

Also having mother present was helpful.

- Made victim feel believed and that it wasn't her fault.

Memory of how RCMP officer had treated her as someone to be believed.

Talk to her and made her feel good, "not your fault"

Let her know it wasn't her fault.

- Helpful suggestions and information.

A journal that social services got her to keep.

The fact that they assured her that her friend wouldn't hate her for reporting her father.

1b. Please indicate anything which was helpful to you during the CFS investigation.

- ***Helpful to my child.***

Made her daughter feel good and Social worker said she could call her anytime.

That they helped her get it out in the open.

- ***Someone there for me.***

My minister being there with me at the meeting.

Just having the support of Social worker and the police officer. They were almost like friends.

Nothing much, they did keep assuring me that I had done everything I could do.

Social worker was really good and listened. She let me talk when I needed to. She even came out to work to see me.

They let Mom know that they were there to help - behind them.

Support from staying at Anderson House and everybody involved at the time.

- ***Allow me to be involved.***

Listened to mom when she asked them to back off - knew when to step in

Allowed me to go in the back door after (asked)

- ***Help validate the abuse.***

Social worker was helpful because she was very up front. It was finally documented at social services. It took pressure off me.

The interview itself helped mother because she knew then that the allegations were true.

2a. Please indicate things which were unhelpful to the victim during this period.

- ***Process creates powerlessness of victim and mother.***

Whole process, not organized, she had to go to others, chaos,
travelling in town.
No feedback.
Social fear.
Lack of support.

The doctor's examination. The doctors examination caused her daughter to loose her virginity. She felt re-victimized and felt she had no rights to say "no". The doctor was requested by social services. They wanted him to do the entire Rape Kit, which was inappropriate. It shouldn't have such an issue. I was extremely angry with everyone, and I was angry at myself for not protecting my daughter. She was more defeated at that time and wondered if she could handle it.

When I first reported the abuse they asked me if I wanted to put my son into foster care until everything was settled. How would that have helped? I was so upset about this.

Investigation interview - not their fault. He just didn't understand what was going on.

- ***Process is no support to her the victim.***

She didn't have anyone to talk to to help her or the family.

No one really encouraged her enough to talk about the abuse. She refused to talk but someone should have encouraged her to get counselling.

Whole process, not organized, she had to go to others, chaos,
travelling in town.
No feedback.
Social fear.
Lack of support.

- ***Process outraged confidence of victim in system.***

Broke confidentiality.
Lied to her. Used her interview against her and her father.
Forcible removal from home at a later date (4 mths. later)

- ***Negative attitude of helpers.***

They were not receptive to sympathetic condescending attitude.

When we were told we had to go to court, this upset her very much. The probation officer called and told us. Didn't prepare us, just flatly told us over the phone. He didn't explain why we had to go to court.

The doctor's examination. The doctors examination caused her daughter to loose her virginity. She felt re-victimized and felt she had no rights to say "no". The doctor was requested by social services. They wanted him to do the entire Rape Kit, which was inappropriate. It shouldn't have such an issue. I was extremely angry with everyone, and I was angry at myself for not protecting my daughter. She was more defeated at that time and wondered if she could handle it.

Police were there.

3. If you were going to recommend changes in how Child and Family Services investigated your child and family, what would you recommend?

- Use more trained professionals child therapists/CSA experts.

Not be part of it.

Trained professional child therapist.

They can watch two way mirror.

Not change workers during process.

Why do social services have to investigate. They should send the child to professionals who are experts in sexual abuse.

- Do not treat all cases the same.

Do not treat all cases the same, each is individual, all people deal with it differently. Mom felt badgered and they said Mom wasn't normal. Because of the way she handled the situation.

They seem to stress that it is not my fault, but I never thought it was. They seem to say what they think you want to hear. They seem to blame the parents.

Need more information. Not totally rely on text books vs. real life. Uniqueness of each case.

- Advice, involvement and decision making for the victim/mother.

Advisory council to let Mom and daughter know the pos and cons of pursuing it. Easy not too hard to do anything.

Give a choice to victim as to where meeting takes place.

A recognition, verbal compassionate by workers affirming how difficult it is to go through this process of investigation. Plain simple words. "This is hard". "You are brave". Make us feel believed.

More feedback should be given to the parents about how to deal with my daughter.

- Could be better organized.

Be more organized.

Be more protective of victims. Not themselves fear of implication.

Perhaps if there was a way to minimize the amount of interviews.

- ***There needs to be more support for victim/parents.***

They should allow a supportive other person to accompany the victim during the investigation.

It's not necessary to put the child through the whole rape kit. It underminds us.

It would be helpful to have more support for the parents at that time.

Patience and understanding.

- *General concerns.*

Do not get emergency workers to call in middle of the night (suggestion that perpetrator shouldn't be there). Can not verify who they are, "who are you?" Didn't ask her to see if Mom could be there and Mom was told they would and she relayed the message to daughter- mom lied.

Social services should interview first to see if there is a valid concern, then call police.

They stress our economic and social situation too much. They asked a lot of questions about what my daughter did for hobbies, who she played with.

Social worker was suppose to tell other family who were babysat by same people and they didn't tell them for three weeks after the disclosure. They should have told them sooner.

4. What, if anything could have been helpful to victim to be able to cope better during this investigation process?

- Knowledge on rights, what will happen.

Advocate, give info.

Someone to explain mom's rights - more support for the children's protection - right to privacy.

More awareness - a video to show the process of one case from start to finish (no identity)

Let her know that if she gets through this, her life will begin again.

Someone - one person - who could have explained what would happen and how things would happen. We didn't know how things would proceed.

- Support to mothers/victim.

Possibly having an opportunity to talk to another women who experienced and have the same dynamic of still having feelings and caring (love and hate for husband)

There wasn't anything that really could have helped. I had support from my AA group, my friends, neighbours. I got support from Victim Services.

More support for parents.

Reassured that mom was not to blame.

Mother should have been more involved, should have had a centre that specializes in sexual abuse.

Not to be told so many negative things - support for her and offender as well as victim.

- Organized better for the victims.

Not have change of worker, ie. financial

One group at a time to interview her, needed time to collect thoughts, feelings.

The process takes too long, the process should be shortened.

- ***Other comments.***

Criticism from perpetrators family was the most negative part.

Nothing more.

Nothing suggested.

It was as good as could be. They were very informative.

5. What, if anything, would have been helpful to the victim to be able to cope better during this investigation process?

- ***Allow mother to provide support to their child.***

Mother should have been more involved,

Should have had a centre which specializes in sexual abuse.

She wanted to stay with her mom and sisters at Anderson House rather than in a foster home where she was living at the time.

She could have been better prepared to go through the process. It would have been more helpful to have her mother with her during the investigation.

To be allowed to have her mother with her during the investigation.

To have counselling right away.

Someone could have given the parents written information or other information so they could help the child at that time.

Support mom

Ages - pressures off mother so she'd be available, ie. assigned buddy but education.

- ***Provide support and resources to victim.***

Let her know that if she gets through this her life will begin again.

Constant reassurance that she is OK - everything will be fine - understand her needs.

- ***Better organized process.***

He might have cooperated a little better if he had met the investigators before.

It takes too long. It is hard on the victim to wait.

- ***Other comments.***

Criticism from perpetrators family was the most negative part.

Let her know that if she gets through this her life will begin again.

6. What things should be changed during the investigative process to make things better for victim?

- The process takes too long.

Take it slower over a period of time. Make a more personable for age.

Avoid delays.

To be considerate of child's age. Avoid upsetting the child in any way possible.

The process should be shortened.

It was a dragged out process from the day it happened to the day it went to court. The process should be a lot shorter, there were too many delays. It happened in May and was booked into court in October. It was postponed again until April. Nearly one year later.

- There is the need for a support system for family and victims.

Groups/meetings for extended family, support people to educate them about dynamics of sexual abuse, how to effectively support victims, families. Like Alanon. Access to knowledge of support system to help kids and family. ie. a way to meet people with similar problems. But stressing the individual uniqueness of each persons experience to pain.

They need to set up a support person, who is not associated with social services, who can help the victim through it. Someone who is like a Big Sister who can support them but doesn't have authority over them.

- The process is not well organized and sensitive to children.

Victims should not have to be investigated. Re-victimized. Fearful of someone going to jail or someone hunting someone. Feeling or responsibility of mom.

Social services workers shouldn't have come to see her at school so much. Do not lye to get them to say what they want to hear. Everything happened, didn't let her know before hand. "Surprise, no change to discuss it with social services and police were there". Do not tell victim what the offender will plead unless they really know - unless he says.

Get off their asses and do something. Get priorities straight. Change system.

They should have reported it to social services, maybe daughter would have gotten counselling then.

The whole procedure at the hospital has to be improved.

Meet the investigators before the questioning.

Too much interviewing and confusion.

In our situation it went well and went quickly. Sometimes it takes too long to get to court. Sometimes the investigators are too nit picky. Sometimes the details asked for seem a little to fine.

- ***More trained skilled therapists.***

Trained child therapist.

Need more professional expertise - a centre to help the whole family. We all felt like victims - we felt like we betrayed our kids.

- ***Other comments.***

No - things were good for her.

Changed discussed in the police section.

A book on sexual abuse to read to the child, like the "Silver Horse".

7. Please describe the most helpful events/experiences that assisted you in coping with court process.

- ***Crown***

The crown has been extremely helpful. She is able to explain things to me so that I understand. She met with me for over an hour at my request.

The crown prosecutor let us sit in the back behind the court so we didn't have to face the offender.

The crown,

- ***Victim Services (having information)***

Victims services, past experiences.

Victims services.

Knowing the procedures. Having worker explain all of the procedures.

Victim services, worker - gave her information about what was happening in the court.

- ***Child Protection Worker***

- ***The Lawyer***

- ***Friends***

- ***Homemaker***

- ***Counsellor***

- ***Minister***

- ***Nothing***

8. Please describe the most helpful events/experiences that assisted the victim in coping with the court process.

- *Family*
- *Victim Services*
- *Social Services*
- *Crown*
- *Friends*
- *Minister*
- *Victims avoidance/blocking*
- *Nothing*
- *No testimony (none)*

9. If you could make changes in the court process to improve it and to support the victim, what would those changes be?

- Speed it up.

Offender to get into court process a lot sooner. Not drawn out.

When there is a child involved they shouldn't have to go to court in the first place. The process should be shortened, shouldn't drag on.

Felt the offender should have gotten help sooner. He admitted guilt and wasn't in court until 6 months later.

The verdict should have been handed down immediately after the case is heard.

Judge had decided to put him jail no matter what the lawyer said.

Not published in paper, the paper published his name. We were not advise of their rights as far as public knowledge goes.

Make sure there is no connection between judge and the case people.

Politics and religion should stay out of the court room.

Better lawyer preparation.

- Better court preparation

Better court preparation. The first time we had not even seen our statements. Crown prosecutor needs to be experienced and have time or others have time to explain court process to victims and families.

Preparation to know what to expect.

More communication from police, courts.

- Sentencing

There should be a minimum sentence for a sexual offense. The sentences should be longer. You get more of a sentence for stealing a car than for ruining someone's life through sexual assault.

To know that the person who assaulted you is walking the streets is not healthy. Why not keep the perpetrator in jail prior to the court date.

He pleaded guilty. You felt let down even though she talked to the probation officer and the sentence was what I requested. I remain unsure as to what would have been better because I was never able to find out the extent of what he needed in counselling.

- *Change court procedures*

Accused on stand
Accused should not have a choice in taking the stand.

Screens
Screen

They should use the video taping and the screens so she wouldn't have to face him in court.

Not open court
Not have an open court

There could have been other people there.

- *Other*

Don't know of anything.

They should have published her name his name. She wanted people to know what he had done.

The court house in Georgetown is set up so that she had to sit directly beside him - this is very intimidating. It should be less formal and intimidating.

The defense lawyers should not be able to attack the victim verbally on the stand.

She shouldn't have been allowed to stay in the court room after she had given her testimony.

Victim gets the final say.

10. Do you think this therapist was helpful? If yes, how.

- Helped with difficult feelings

There for her if she wanted to talk. Helped her deal with anger.

Explains things to her. Draws her pictures to explain about her body. Helps her tell her feelings.

The support to her. Helping her to see that she was the victim, not to blame and that she was feeling normal emotions.

Having another adult repeat what I was saying to her. It gave her someone else to see when she felt I was dealing with too much.

He took a lot of guilt away from my son about the abuse.

Therapist helped him think before he acted and be less impulsive.

- Group process

Group process.

The therapist introduced her to other victims of abuse in group therapy.

- Works at child's level, pace

Gave boys opportunity to be children, not adult to communicate

Acceptance

Good reputation, positive, a realist, she's supportive, concerned, aware, young, good communication, at daughter's level.

She helps because she goes at daughter's pace and she is very knowledgeable about sexual abuse.

Explains things to her. Draws her pictures to explain about her body. Helps her tell her feelings.

My daughter wasn't ready for help then. He was very accommodating.

and a negative example
She wanted to put daughter in a group. Daughter didn't want to be with others who had worse things happen to them.

- Open communication

She was able to share everything with Brenda.

Got victim to talk about subject to her parents, open communication more so.

- *Good therapy skills, and knowledge*

Good reputation, positive, a realist, she's supportive, concerned, aware, young, good communication, at daughter's level.

Reason we took her there was because of stomach pain and felt she hated herself. Therapist convinced Mom well that her behaviours were not all the result of the sexual abuse specifically. Assured me that in her developmental stage she was seeking more assurances of love. This seemed to be a stage - therapist was right in terms of child was not dwelling on abuse.

He had great results with other kids in the group.

Intervened and helped right away. There to talk, good therapy. Therapist was helpful, even if the therapy itself was not.

- *Time*

Time elapsed, circumstance changed healing may have been assisted by time

11. Would you make any suggestions for change in the therapy system? If yes, please indicate.

- Intensive support, therapy for families

People able to respond to emergency situations

Sometimes things were so bad I didn't know what would happen. I was afraid if I told how bad the fighting, confusions, controversies were, that the department would take all my children away.

Need more hours, esp. crisis

- Support for family

I wish there was more information about other parents who are going through the same thing.

Service in family day and night

Support groups along the journey

- More focus on parent's needs

Direct more to parents needs.

More people trained to help parents of victims.

- More available sources, more readily

More flexibility/availability

Would like more therapists so they can be readily available.

Need more services

More often than once a week

More extensive therapy at the beginning

- More specialized training

Have well trained therapists

More specialization

Choice of specialists in the area of child sexual abuse and the repercussion on the family

- *Assessment*

The child, no matter what age, should be seen by someone besides the parents to assess if there are any problems as a result of the sexual abuse.

- *Follow up*

Good follow up

12. Do you think this therapist was helpful? If yes, how?

- ***Helped me put things in perspective, see things (changed perspective)***

Helps her focus on positive actions.

She made me see things more clearer. She helped ease my fears. I was so full of fear, but with talking to her she made me see it a different way.

She put things into perspective.

- ***Understanding and support***

Listened to mom, empathic, understanding

She understands our points of view

I don't fear that it will shut down on me

Competent, sincerity, supportive

Listened, did not give advice, but perhaps would like some

Supportive about charging

Positive feedback, suggestions

The fact that both my daughter and I go to see therapist is helpful. She reassures me that I am doing the right things with my daughter.

- ***Offers useful explanations, understandings***

She helped me understand why she needed to go to group home because of her self destructive behaviour.

She explained why my daughter was acting the way she is. Helped me cope with the aftermath of the abuse she has witnessed and experienced.

- ***Affirming and normalizing my feelings and experience***

Affirming in some ways over a year that my feelings are important in this

He has worked through the jail system, group therapies, abuse, etc. He helps me to understand how I feel. He has made me feel realize that my feelings are natural and that I'm not to blame for the abuse. He makes me realize it takes time to get over these kinds of problems. In the future he would like to see the whole family.

- Provides information

She gave me reading material and also a list of books on child behavior and development to read.

She gave me reading material and information about groups out west where I was moving.

- Helps us develop skills

She is making it possible for my daughter and I to understand each other - to talk openly, communicate

Learning how to work out disagreements. Helping me to take control and daughter to respect the family

She is helping us learn how to take care of herself. That she deserves good friends and a good life, helping to build our self-esteem

- Helped reduce self-blame/guilt.

He has worked through the jail system, group therapies, abuse, etc. He helps me to understand how I feel. He has made me feel realize that my feelings are natural and that I'm not to blame for the abuse. He makes me realize it takes time to get over these kinds of problems. In the future he would like to see the whole family.

Helping me with my feelings of guilt and anger a place to tell and get it out in the open.

Helped me to see it was not my fault

Helped with marital problem taking away blaming self and each other.

At that time I did blame myself for everything. She helped me deal with a lot of things.

- Expressed painful feelings

Helped me face pain and get over being saturated with it : avenue to express distress and confusion

Because I knew she would keep everything confidential, I knew I just dump.

13. Would you make any suggestions for change in the therapy system for families? If yes, please indicate:

- ***More time***

- ***More, competent therapists.***

14. Do you think this therapist was helpful? If yes, how?

- *Went only once*

- *Problem solving skills*

15. What, if anything, do you think needs to be done to have others be more understanding and supportive to families and victims of child sexual abuse?

- Public education to break the silence

Public education, workshops, They have to take the word abuse into every home because there are so many children being abused in the home.

Make them more aware of it.
Provide info so CSA is not such a secret - break down ignorance.

Worry sometimes that other people in community who have younger children might be vulnerable because they don't know about the offence.

- To understand the problems, and how to support victims and families better.

Education by victims trained.

General knowledge communicated to everyone about how to support friends/family within this issue.

Education and be aware and sensitive to needs of victims.

People need to be informed about how they can help.
They need to be reeducated about sexual abuse

Examples of CSA, what happens, different situations = tape.

Everybody would get more educated about it
Educational things on TV

Need to educate them

People need to know this: feels it is a sickness, it's a cycle, more education

People should be made aware of the effects of CSA so kids are not considered bad.

More of an awareness and to help put a stop to it

Understand those abused - probably do it.

We've come a long way in terms of education. A lot depends on how people feel about it themselves.

- ***We had a very supportive response***

It's hard for me to say. In our community they would have done anything they could to help.

No - everyone reacted well to her and her daughter

- ***React more supportively and honestly to families and victims***

If people want to know what is going on they should ask the people involved directly instead of spreading gossip. People tell stories, not knowing the facts.

Give people benefit of doubt

Christian charity

Be more understanding, not so quick to jump to conclusions. (of alleged)

Try not to show shock - anxiety

People seem to be more understanding when a female is abused then when it's a male.

- ***Families need counselling and support***

People need to see a counsellor, not go through it alone.

There should be support groups for parents of victims.

- ***Other***

People need to go through it themselves before they can understand sexual abuse.

16. I'd like to think back over all you've been through since your child disclosed the sexual abuse. This would include the disclosure, investigation, interviews, interventions, court, therapy and so forth. What's been the most difficult part of this for you?

- The shock at what happened

When I asked her if she had been touched and she said yes - the initial shock. When she disclosed (hearing her say it)

- The damage the abuse had done to the victim

No one has understood what a loss it is, the grief you feel because your child has totally changed. Even kids see it. She asks "Where has she gone?"

Now, the aftermath - the effects on my daughter.

- The damage that the process covered.

disclosure/investigation
Postponement of process because of first counsellor not identifying for the family.

Handling of the boys disclosure, damaging them.

court
It was all hard. The hardest had to be court - standing outside of the court room and hearing her cry hysterically and not being able to help her. The anger was hard.

Going to court really drained me. The closer it got, the more I dreaded it. I collapsed after the court experience.

Time lapse of court and bet court will be worse

It takes so long to go to court, it drags on and we're afraid when it finally gets to court it will get thrown out.

overall
Waiting for appeal. The feeling is they don't care, don't understand our fear, our anxiety.
The waiting is seriously effecting us
Get the staff and ? to pursue a real justice

They won! Having to watch her children be kicked around by the system
Relocation from a community she has been in since 15.

Frustration at not having contact with father's therapist. Family needs to get information, frustration with social services during investigation

- Personal feelings of helplessness, powerlessness and worry.

Feeling like that even though I had done everything I could do it wasn't enough. I couldn't keep this from happening to her.

Dealing with worrying that you've done the right thing by reporting the abuse.

Not knowing whether or not sexually allured
Feeling of helplessness, own feelings - uncertainty, dilemma ongoing

Not having her home

Dealing with perpetrators feeling to daughter - he has negative feelings about her

I cannot find out how my brother is doing. I would like to know more how he is doing. I just don't know where to find out.

- Betrayed

He was a friend of mine for a lot of years. I felt betrayed by him.

Shock of loved person hurting my daughter so terribly

- Offender not dealt with

The man was not held accountable - still driving children in his taxi

Perpetrator remains free, is dangerous, still causing trouble and there is nothing anyone can do.

- Other

Financial difficulty has made going to appointments, etc. very hard. It doesn't seem to end.

Coping with my mother

17. I'd like to think back over all you've been through since your child disclosed the sexual abuse. This would include the disclosure, investigation, interviews, interventions, court, therapy and so forth. What's been the most helpful for you?

- Some agencies were helpful.

Support from therapist for the Mom

Worker - boys placed with someone

Social worker

Coming to Richmond Centre and seeing therapist

Support from the guidance counsellor

RCMP

Social worker has been most helpful

Social worker, Social Services

Doctor

Our church

Therapy

- That the victim was getting help.

Most helpful is knowing he's getting treatment and won't do it again hopefully.

When my son was sent up to Summerside, I was relieved, because I worried he would commit suicide.

The workers in Summerside have been very helpful

The counselling has helped - to know that someone else knows and can do something.

- Personal friends helped.

Sister in law

Probation officer very supportive, challenging, encouraging, enabled me to express, could help me understand husband, enabled me to express, realistic empathy

Support of all people who helped

Boyfriends support

Music

Friends supportive

My boyfriend, having one person you can say anything

- Personal changes/awareness

Learning that I do know now what it's like to feel like killing someone and still not doing it. This traumatized me so much that I had to face my own sexual abuse.

Inner strength has more tolerant, judgement

- Personal closeness.

Our relationship - if she and I had not had such a close relationship I don't know what would happen

That my daughter got it out in the open

That he got a jail term, even though it was short.

Having to go to work - depending on its structure

Moving from the area. We use to have pass perpetrators place to get to our home

No

The family has gotten closer together and support one another

APPENDIX A.5

Sex Offender
Program Survey

APPENDIX

SEX OFFENDER PROGRAM SURVEY

(Responses to open ended questions)

1. Should convicted offenders serve a jail sentence?

Category "always" - 2 responses

Reasons:

(1) When a person knowingly commits a crime and has control over their behaviour, as is true for sex offenders, then they should be punished.

(2) Punishment serves to indicate our repulsion at these crimes.

(3) Judicial control can be used as a level to get these offenders into treatment which they would otherwise avoid.

(4) Depending on the severity and recidivism. This is essential to enforce accountability for their actions. There needs to be negative consequence to their behaviour. Ideally, treatment, or at least the opportunity for treatment, should be provided during the incarceration.

Category "almost always" - 2 responses

Reasons

(1) There may be isolated incidences where jail may not be appropriate i.e. where a boyfriend/girlfriend relationship exists and the age difference would constitute an offence. In one case the couple had a baby and both were intent on continuing the relationship. No level of manipulation existed.

(2) It is necessary that treatment be available for sex offenders inside the jail, otherwise only a short-term deterrent and protection for the public is provided.

Category "sometimes" - 2 responses

Reasons:

(1) In some cases, lack of jail sentence makes offender minimize the crime: "What I did wasn't so bad." In some cases, the "carrot" of parole is a very useful incentive to get offenders to commence treatment. (One program

wrote stating that they provide treatment as an alternative to incarceration.)

2. What are the factors which you would consider important in determining whether there should be a jail sentence?

   (1) Danger to community.
   (2) Denial/minimization.
   (3) Violence.
   (4) Type of sex offence, i.e. incest vs. rape.
   (5) Amount of violence/victim impact.
   (6) Pattern of sexual deviancy.
   (7) Community support in terms of family, treatment facilities, etc.
   (8) Is retribution a consideration.
   (9) Would it function as a deterrent for further offending.
   (10) Is a probationary period with treatment likely not to be as effective as the above.
   (11) Is sex offender treatment available in the incarcerated institution.
   (12) Any degree of manipulation by the offender and/or where the offender takes advantage of a situation for his or her own gain.
   (13) Recidivism - as it increases, so should the length of sentence (number of offenses) - as they increase, so should the length of sentence, i.e. a pedophile on first conviction but has a 10-year history of pedophilia - should be based on risk assessment as well as capacity for empathy, accountability, motivation for treatment.
   (14) That a crime was committed by the accused.

3. What are the factors which you would consider important in determining the length of the sentence?

   (1) Prior history of offending.
   (2) Degree of force used.
   (3) Degree of sexual intrusiveness.
   (4) Whether a position of trust or authority was abused.
   (5) Victim impact.
   (6) First-time offenders of less violent and numbered offenses may be managed with community outpatient treatment. This should be carefully assessed and followed for risk to reoffend (at present), progress in treatment.
   (7) There should be allowance for offenders to be put in secure facilities as determined by probation, parole and treatment teams.
   (8) Circumstances of the offence including (a) any violence or

threats, (b) the degree of manipulation, (c) the extent of exploitation of victim, i.e. physical/psychological, and (d) the relationship of offender to victim, i.e. violation of trust.

(9) Severity of offence.

(10) Treatment availability within the institution.

(11) Damage to community, denial/minimization, and violence.

4. In your opinion, do longer sentences have a deterrent effect on:

(a) the current cases being sentenced? (3 yes's; 3 no's)

Reasons:

(1) Yes, so long as the opportunity is seized to immediately begin rehabilitation process.

(2) Yes - Longer sentences are preferable if treatment is available. Sentences don't necessarily have to include a secure environment. If progress is made, offenders need to be slowly reintegrated into the community so outpatient treatment is possible.

(3) Yes - Providing the sentence has an educational and/or treatment component.

(4) No - There is no evidence that they do or don't. Certainly in an exclusive pedophile who emerges untreated there is no reason to expect change.

(5) No - Generally speaking, punishment alone will not deter sex offenders. Very few are situational offenders. If a longer course of treatment is provided with a longer sentence, this may have an effect on recidivism.

(6) No - I doubt that jail is much of a deterrent to most offenders.

(b) on other offenders? (1 yes; 4 no's; 1 ?)

(1) Yes - It sends a clear message, if the case is publicized in the media, that we regard these crimes as reprehensible.

(2) No - Sex offenders have psychological problems that punishment alone will not cure. It is, however, important to show society's condemnation of sex offenses with serious sentences.

(3) No - It appears that many offenders lack in empathy skills. This, coupled with their ability to rationalize unless confronted, leads me to believe in most cases they see their case as being different from convicted offenders and therefore the deterrent effect will be minimized.

(4) ? - Most offenders don't view incarceration as a deterrent because they don't think they'll get caught. Repeat offenders may find the knowledge that they'll get longer sentences if caught a deterrent.

5. In your opinion, do shorter sentences encourage further abuse for:

(a) the current case being sentenced? (3 yes's; 3 no's)

(1) Yes - It is possible that this could reinforce the deviant behaviour. Each case must be reviewed individually.

(2) Yes - In that the shorter sentence is seen as less of a deterrent vs. a longer sentence. In our justice system, length of sentence is determined by the "seriousness" of the crime. Receiving 2-3 years for a sexual assault does not make it appear as a terribly "wrong" or "bad" thing to do.

(3) Yes - They tell the offender that we think the offence was trivial.

(4) No - I do not think they encourage further abuse; however, regardless of the length of the sentence, without intervention we are not addressing the problem.

(5) No - The dynamics in offending, in my opinion, succeed in denying that the offender will be caught or, if caught, will be dealt with harshly.

(6) No - No evidence one way or another. My belief is no.

(b) other offenders? (3 yes's; 2 no's)

(1) Yes - Same as above.

(2) Yes - They tell other offenders that we think sex crimes are trivial.

(3) No - I do not think the sentence of one offender makes an impact on others given their ability to rationalize and not draw parallels between their cases and others unless confronted with same.

(4) No - Same as above.

6. In your opinion, are sentences for sex offenders usually too harsh, just about right, too lenient?

Category "just about right" - 4 responses

Reasons:

(1) The federal offenders which we deal with (2 years +) seem to be receiving appropriate sentences.

(2) It is very idiosyncratic, but in general appropriate.

Category "too lenient" - 2 responses

(1) This seems to be related to the idea in the justice system that physical violence is the "most serious". Many sexual assaults (particularly against children) involve coercion rather than physical violence or weapons, etc. This is based on the myth that sexual assault doesn't cause physical harm;

therefore, it's not as serious and not as painful. It disregards largely the incredible emotional impact sexual assault has on the victim. It also sends a message to offenders.

7. From the perspective of treatment and rehabilitation of sex offenders, please indicate the possible effects of the following:

(a) going through the court process:

(1) Usually so much in denial it doesn't affect them, although for some it is definitely a humiliating experience and therefore can be therapeutic in terms of "consequences" of reoffending.
(2) May help with denial/minimization.
(3) Reinforces seriousness of the offending behaviour.
(4) May help with subsequent empathy work.
(5) Has a salvatory effect even if a prosecution is not secured, and it often leads the offender into treatment. Also allows him to see the harm he has done to the victim.
(6) Breeds resentment but also is deterrent in my opinion.
(7) Little effect if any, given that many sex offenders do not accept responsibility for their actions unless confronted. Sometimes the court process may cater to the offender's ability to deny his actions and therefore treatment is an important component.
(8) Confrontation of sexual deviancy, hopefully acceptance of some responsibility and a realization of the impact on the victim. Opportunity for assessment.

(b) jail sentence:

(1) Opportunity for counselling and treatment.
(2) Protection for the public.
(3) A jail sentence without educational and therapeutic components offers little with respect to treatment and rehabilitation.
(4) Depends on nature of institution and whether treatment is available.
(5) Allows offender to fully appreciate the gravity of what he has done and gives us a chance to get him into treatment.
(6) Reinforces seriousness of offending behaviour.
(7) Offers chance to begin treatment under controlled conditions with carrot of parole as motivator.
(8) Again, this works for some and not for others. Typically, the criminalized sex offender may not view jail as a serious deterrent while the first-time incest offender who is incarcerated seems to be more likely to.

8. If you were going to develop a training program for Crown Prosecutors and judges, what major areas would you cover?

(a) Crown Prosecutors:

(1) Impact on victim, both short and long-term.
(2) Need for and value of treatment/rehabilitation.
(3) Tip of the iceberg in most cases (at Abel's work).
(4) General knowledge of characteristics/dynamics of sexual offending.
(5) The value of sentencing.
(6) The value of prosecuting, even in less than strong cases.
(7) Use of expert evidence.
(8) Different "types" of offender; their crime cycles.
(9) Family systems of offenders.
(10) Second degree victimization due to legal processes.
(11) Nature of available treatment.
(12) Importance of mandating treatment.
(13) I would think it would be important to note the offender's ability to minimize, rationalize and deny particulars of the offence.

(b) judges:

(1) Availability of treatment resources for sex offenders in the community and institutions.
(2) The parole board process.
(3) Recidivism rates for various types of sex offenses.
(4) If judges were sensitized to the above-noted information (see 8a), along with the crown prosecutors, a step would be taken in the right direction. The onus of responsibility for one's actions needs to be highlighted.
(5) Denial, minimization, rationalization (don't buy into it). What one sees is just the tip of the iceberg (Abel's work).
(6) Further impact on victim as result of judge's decision.
(7) Gender roles!
(8) The dynamics of sexual assault, i.e. it is based on power and control, not sexuality.
(9) Wives as victims are no different than strangers!
(10) Adolescents with sexual assaults are not just "boys experiencing their newfound sexuality" - they are deviant and must be dealt with in treatment!
(11) Sex offending behaviour that is not halted seems to be cross generational, i.e. abuse leads to increased chances of abusing others or putting yourself (victim) in a relationship that is unhealthy and abusive. Stop the cycle with treatment.

9. What important assessment information should the court be aware of in sentencing

an offender?

(1) An evaluation by an experienced and trained professional covering the broad scope of causes and present risk.
(2) Phallometric evaluations are useful but their value has been markedly overestimated, particularly where they reveal little arousal or where they show normal responding - in neither case does such information tell us anything regarding the man's guilt or his risk to reoffend.
(3) Degree of denial of offence is the most important factor in assessing risk to reoffend.
(4) Treatment availability and necessity.
(5) Recidivism.
(6) Denial, minimization; pedophilia diagnosis; psychosis (rule out); antisocial personality diagnosis - speaks to treatability and safety to community.
(7) Motivation for treatment.
(8) History of sexual deviance.
(9) Victim impact.
(10) Degree of violence, threats, manipulation re offence.
(11) A psychological/psychiatric assessment should always be completed.
(12) Empathy/insight into the offence and personal problems.

10. Please indicate the length of sentence you would recommend including the main factors to be considered.

(1) Minimum length should be 2 years. In an idealistic world, offenders should be given indefinite sentences to secure treatment. Depending on their progress in treatment, they should be given more or less limits eventually leading to a slow progressive release.
(2) Minimum of 9 months - long enough for treatment to begin in jail and to use parole as a motivation - incest-type. Two years plus - with violence; very compulsive child molesters - longer term treatment completed while in jail and safety to the community.
(3) Four to 6 months - an isolated incident; lower degree of manipulation; lower level of harm done to victim. Two years less 1 day - forced sexual intercourse; use of violence, threats.
(4) This depends on the availability of treatment.

11. From your experience with the justice system, what changes would you recommend to improve management and treatment of offenders in the following areas?

(a) the law itself:

(1) The vagrancy law could be strengthened so that known sex offenders

frequenting playgrounds, etc. could be easily charged.

(2) A breakdown of sexual abuse in the Criminal Code.

(3) Mandatory supervised probation with sex offenders.

(4) The option of having probation with federal time.

(5) I like the revising making it easier for witnesses (child victims) to testify and in making it easier to prosecute.

(6) Do not do away with the victim protection shield. This feeds into offenders putting responsibility onto someone else.

(7) Recognition that sexual assault is violent in itself, whether or not weapons, physical abuse, etc. occurred and sentences that reflect this.

(8) Changing witness procedures to protect victims, e.g. having them testify in a separate room shown on video in court, and denying under any circumstances cross-examination which investigates the victim's prior sexual history or any other aspect of her/his personal history.

(b) police investigation:

(1) Greater training in dealing with victims so that they can investigate and yet support the victims.

(2) Victim's character has absolutely nothing to do with sexual assault - stop including it in reports!

(3) Details of the offence, victim response and impact statements are incredibly important in offender treatment because they deny, minimize and rationalize. It's difficult to confront when you don't have accurate and complete details.

(4) More training - specialized officers - victims need special treatment.

(5) Closer liaison with child welfare agencies.

(6) Mandatory entering of previous convictions highlighting any offence related to sexual deviance.

(7) Training sessions re sexual abuse.

(8) Victim impact statements should always be completed.

(9) Female officers should always be available to interview female victims.

(10) Information should be shared with the victim regarding the court and parole process.

(c) Crown Prosecutors:

(1) Greater sensitivity to victim's concerns regarding testifying in court.

(2) Access to psychological and/or psychiatric reports.

(3) General training re sexual abuse.

(4) Knowledge of available services.

(5) More assistance for victims in helping them to testify.

(6) More knowledge of sex offending to seek appropriate sentences.

(d) judges:

(1) Efforts to ensure proper protection of victims from offensive/ aggressive cross-examination.

(2) Many defence lawyers try to convince that these men are upstanding citizens, i.e. help with the community, etc. These things may be true but they don't overrule the fact that they sexually assault people, i.e. many pedophiles, as part of their offence pattern, are Boy Scout leaders, good with kids, etc., or in positions of power. This is their set-up to offend, not a reason to believe they couldn't have committed such an offence.

(3) More standardization - similar offenses now range from dismissal, through release, through intermittent sentences to federal (word illegible)!

(4) More standardization between provincial supreme court and provincial court.

(5) Pre-sentence reports to be completed for court.

(6) General training re sexual abuse.

(7) Knowledge of available services.

(8) Discreditation of the victim's reputation should not be allowed.

(e) correctional centres:

(1) Separate treatment facilities for sex offenders should be provided. The staff should have expertise in treating these individuals. Intensive comprehensive treatment is needed.

(2) More educational, self-awareness and group intervention at this level.

(3) More specialized centres for sex offenders with treatment opportunities.

(4) Treatment programs at an institutional level. Right now provincial inmates have very limited access to treatment.

(5) Halfway house, community follow-up connections are necessary. Sex offenders find little support although they require a lot of it.

(6) Separate institution to treat sex offenders, offering treatment (at low intensity for a start) as soon as the offender arrives in jail. Creating a genuinely therapeutic environment while maintaining security, particularly peripheral security.

(f) probation/parole officers:

(1) Training in relapse prevention procedures and assigning special officers who are well trained to supervise sex offenders.

(2) Decrease caseload for closer supervision of probationers/parolers so that attendance to various programming could be more closely monitored.

(3) Increased education to these supervisors regarding the dynamics involved with particularly offender type, e.g. recognize importance of sex offender having sex offender specific follow-up treatment.

(4) More appreciation of need to treat the offender (i.e. order to treatment) and

need to intensively supervise.

(5) Continued emphasis on addressing need and risk areas.
(6) More group intervention.
(7) Annual workshops highlighting issues.
(8) Accessibility to police reports re offenses.
(9) Networking with other justice personnel and child welfare re offender and circumstances.
(10) Probation officers need more time to complete pre-sentence reports and to acquire assessments.
(11) More training should be provided to parole and probation staff.
(12) Smaller caseloads supervised by "specialists" are necessary.

12. Coordination and cooperation with other systems such as police investigation, child welfare, and Crown attorneys appears to be an important element in the provision of treatment services to sex offenders. Have you developed any models, strategies or approaches to deal with this? (2 yes's; 3 no's)

(1) Yes - We have advisory committees consisting of various agencies that meet once every one or two months.
(2) Yes - We have a sex offender committee in Vancouver which meets monthly. It is comprised of police, provincial and federal agencies, and psychologists.

(3) No - Nothing formalized has been developed; however, case workers liaise with the above-noted agencies independently.
(4) No - We are limited in what we may share with other agencies due to the offender's right to privacy and conflicting confidentiality policies with C.S.C. and within our Centre itself. There are many other factors involved here which hinder agency cooperation. (Note: The obvious objective is victim protection - both present and future. Any information provided by offenders should be open and available to those involved.)

13. In your opinion, should all offenders be required to have treatment? (5 yes's).

(1) Anyone who commits a sexual offence obviously needs treatment and all can benefit from it. Of course, offenders with very long sentences would have to get low priority until release is at least possible.
(2) Treatment follow-up is especially important. In the Prairie region it is also very difficult to coordinate. Follow-up should consist of continued group treatment, not just visits with parole/ probation officers.
(3) General sex education and self-awareness issues need to be addressed prior to group intervention of a therapeutic nature.
(4) Voluntary treatment is most effective as motivation contributes to a successful treatment outcome. The majority of sex offenders need

treatment to address their deviant behaviour.

(5) People offend for a variety of reasons. They need to understand why and how to satisfy those needs without offending.

14. What important issues should a judge address in ordering treatment for offenders?

(1) Denial, minimization.
(2) Motivation for treatment.
(3) Mental illness.
(4) Intelligence.
(5) Organicity.
(6) Personality.
(7) Availability of treatment.
(8) Qualifications of practitioner/program.
(9) Mandate of agencies respecting intervention.
(10) Ensuring that offender, if at all possible, gets treatment specific to his problem areas.
(11) Judges may only suggest, not order, treatment once offender is convicted, as he is under authority of either provincial or federal Corrections, not under that of the courts. When ordering treatment as part of a probation order, a judge has the authority to do so, and should be aware of which programs are effective and appropriate.
(12) At present if a man goes to jail, what a judge orders is ignored.

15. What are the main issues which judges usually do not address in ordering treatment?

(1) In our region the judges are knowledgeable (through our efforts and work over the years) and so their directions are usually good.
(2) The availability of psychological assessments and offender profiles.
(3) Victim impact statements are often overlooked.
(4) Motivation of client - treatment is "voluntary" in all federal institutions.
(5) Treatment and monitoring often need to be ongoing, not expiring upon the completion of a program.

16. Are there groups or types of offenders and offending patterns which might predict a positive or negative outcome for treatment? (2 yes's)

Category "positive":

(1) Incest-type - 1 victim/opposite sex, teen/victim, one or few occasions.
(2) Incest - 1st offence, responsible, isolated, no subsequent abuse.
(3) Incest offenders, 1st offenders - within the family with the opposite sex child.

(4) Willingness to accept responsibility, ability to develop empathy.

Category "negative":

(1) Denial or minimization of crime or failure to fully accept responsibility.
(2) Degree of force.
(3) Sexual intrusiveness (i.e. intercourse vs. fondling).
(4) Low IQ (below 80).
(5) Younger age.
(6) Many paraphilia (i.e. rape, incest, lengthy history of deviancy - offends across gender, age, within and outside the family, violence.
(7) Exclusive committed pedophilic interest.
(8) Exhibitionists - compulsive, many victims.
(9) Pedophiles - same sex.
(10) Obviously the longer the offender has spent behaving in a certain way - it would seem it is that much more difficult to change. The diversity of sex offenders does not generally allow for sweeping generalizations re treatment outcome.

17. What are the most important elements required to make a program for sex offenders effective?

(1) Involvement of offender's family.
(2) Motivation of offender.
(3) Deal with offence cycle.
(4) Behavioural treatment for compulsive offenders.
(5) Qualified and knowledgeable therapists.
(6) Intensive treatment program with 1-1, group therapy, plethysmograph, and assessment.
(7) Structured program focusing on the crime cycle, responsibility and relapse prevention.
(8) Involvement of the community support network.
(9) Cognitive/behavioural.
(10) Consistent.
(11) Confrontational but non-judgmental.
(12) Group therapy is a must!
(13) The goals are what are important.
(14) Change cognitive distortions, i.e. denial, minimization, take responsibility.
(15) Social - empathy for victims, anger control, social competence, relationship skills.
(16) Sexual - deviant preferences, understanding of needs, knowledge/ understanding of attitudes/behaviours that facilitate sex satisfaction.
(17) Life skills - budgeting, job search-and-secure, constructive use of leisure, control of use of intoxicants.
(18) Relapse prevention management - (a) internal management, i.e. offender

needs to learn factors and processes that put him/her at risk and how to avoid these or deal with them if they occur, and (b) external supervision after discharge from formal treatment.

(19) This depends on the mandate of the program, i.e. educational, therapeutic; however, a confrontational approach is essential. Sex education, victim empathy, responsibility issues, family effects and relapse prevention all appear essential components to be addressed.

18. Please indicate the strategies you utilize in providing treatment to the following groups and any specific problems you often encounter.

(a) intrafamilial offenders - problems:

(1) Close proximity of victim (monitoring essential).
(2) Offender and spouse playing each other against caseworker.
(3) Difficulty in wearing different professional hats to assist in dealing with the independent needs of those involved.
(4) Concepts of self-worth and self-esteem must be dealt with
(5) Issues of unmet needs.
(6) Sexual problems.
(7) Very rigid; lack of empathy.
(8) Denial, minimization, resistance on part of offender and his family.
(9) Probation officer or other referral agent buying into the offender's rationalizations.

(a) intrafamilial offenders - strategies:

(1) Offence cycle.
(2) Relapse prevention.
(3) Group therapy.
(4) Adjunct psychiatric/drug/marital/individual treatment.
(5) Penile plethysmographic assessment.
(6) Repetitive, consistent confrontation re attitude and behaviour.
(7) Increase empathy.
(8) Cognitive/behavioural.
(9) Recognizing the need to make referrals and do much networking between agencies.
(10) We never have as a goal the reintegration of the family. This may happen but we do not aim for it. The particular strategies are far too many to list and, in any event, it is the goals of treatment that are important, not the particular procedures. However, I have enclosed three articles which may be helpful.

(b) extrafamilial offenders - problems:

(1) The possibility of there being less contact with the victim (less monitoring through victim).
(2) Unresolved conflicts.
(3) Personal sexual abuse as a child.
(4) Possible regressive pedophilia.
(5) Denial, minimization, resistance on part of offender and his family.
(6) Very rigid.
(7) Lack of empathy.

(b) extrafamilial offenders - strategies:

(1) Repetitive, consistent confrontation re attitude and behaviour.
(2) Increase empathy.
(3) Offence cycle.
(4) Relapse prevention.
(5) Group therapy.
(6) Adjunct psychiatric/drug/marital/individual treatment.
(7) Penile plethysmographic assessment.
(8) Behavioural techniques to deal with inappropriate arousal.
(9) Cognitive/behavioural.
(10) Continued networking (child welfare, police, etc.)

(c) offenders who are considered dangerous or violent - problems:

(1) How many age and gender lines have they crossed.
(2) Anger and conflict.
(3) Abuse as a child.
(4) Power and control.
(5) If they are actively fantasizing and dangerous to staff, we are unable to treat at that time. We will reassess for treatment at a later date. This includes aggressive towards other patients that disrupts others' treatment, i.e. fist fights, pressure for sexual favours, etc.

(c) offenders who are considered dangerous or violent - strategies:

(1) Aversive conditioning.
(2) Covert sensitization.
(3) Cyproterone acetate.
(4) Safety and security of staff is always a consideration.

(d) other offenders groups - problems:

(1) Dealing with offenders that have psychiatric problems and/or are handicapped.
(2) Illiterate/low-functioning.
(3) Other than English native tongue.
(4) Exhibitionists.

(d) other offenders groups - strategies:

(1) Special extra group to review material
(2) Use cassettes for assignments.
(3) Interpreters as necessary. Native elders can be terrifically helpful.
(4) Networking and referrals are essential.

19. Do you identify major differences between adolescent and adult offenders in:

(a) how you understand and conceptualize their offenses? (1 yes, 2 no's)

(1) Yes - For adolescents we are careful not to approach the problem in a way that would encourage them to label themselves as "deviant" which, from what we know of labelling in youngsters, would likely lead them to fulfil the role. Otherwise, quite similar.

(2) No - Basically adults have done the behaviour for a longer period of time than adolescents and usually require longer treatment. The dynamics are essentially the same; however, adults generally have had more reinforcement for their behaviour.
(3) No - Both appear to be locked in the concrete/operational stage.

(b) the treatment strategies you use? (1 yes, 1 no)

(1) Yes - Sometimes, in those cases where there appears to be just 1 or 2 offenses, we use contingency management rather than treat them as deviants. If deviant, then the same as adults except we do not assess sex preferences in offenders under age 16 years.

(2) No - Again, adults and adolescents require essentially the same type of treatment but adults may require stricter limits and longer treatment.

(c) treatment outcome? (2 no's)

(1) Same as above.

20. One issue which is often discussed is around the area of family reunification in intrafamilial abuse. In your opinion, with which of the following would you most often agree?

Category "some offenders should be reunited with family" - 4 responses

Reasons:

(1) Most intrafamilial offenders, in my opinion, do not have a sufficiently close relation with spouse (which is part of cycle that allowed them to offend) to warrant reunification.
(2) Each case is unique and a detailed social history and victim impact would be necessary prior to supporting reunification.
(3) Where the victim is still in the family and still at risk, reunification should not be attempted. It should in any case be cautious and gradual.
(4) The entire family must receive treatment/counselling. The dynamics are so intricate and complex, and "family" is so emotionally charged that often offenders are placed back in families and nothing has changed. Emphasize the offender is the only accountable person for sexually offending - not a "family problem".

Category "very few offenders should be reunited with family" -1 response

Reasons:

(1) The long-term outcome, as I observed as a consultant to U.S. National Institute of Mental Health programs, of reintegrating incest families is poor - this is true for Giaretto's program and others. David Finkelhor has made same observations.

21. Please indicate any preconditions you set to accept an offender into your program.

(1) None - We work on denial initially. 60% of our clients deny at first and we get 60+% to change their mind. The remainder we do not accept into treatment but we would try further with them if we had resources.
(2) We look at responsibility for offenses - if they deny it, we don't take them. Also, we look for some evidence of motivation, i.e. upgrading education, seeking out educational counselling sessions in their institution.
(3) Any offender serving a federal sentence (2 years +) for a sexual offence or a sexually related offence.
(4) With respect to probation supervision which involves one-to-one counselling there are no preconditions. An offender is mandated to report.

(5) With respect to the educational group approach currently operational there are no preconditions. Offenders are either in custody, on probation or parole. Offenders have varying degrees of acceptance of responsibility.
(6) Rule out (normally): psychosis (provide drug treatment), organicity, denial (complete), antisocial personality (other).

22. Are there offenders whom you think should only be treated in a closed setting? (5 yes's)

(1) Yes - Those who constitute an immediate danger to the community. We have been examining the value of sepotonergic/anti-compulsive drugs with these offenders (i.e. busperone) and our results to date are very encouraging and allow us to subsequently see these offenders as outpatients. Ordinarily we do not use medications but for approximately 5-8% of our clients some protection for community seems essential.
(2) Yes - Those who are at high risk to reoffend should be in a secure facility.
(3) Yes - There are certain violent sex offenders who will probably never be safe to release to the community (few in numbers). Most are serving indefinite sentences.
(4) Yes - Those at very high risk to reoffend; high risk at violent reoffence; complete deniers (although not usually treatable).
(5) Yes - Particularly violent offenders who are unmotivated respecting intervention.

23. How do you keep offenders motivated to accept and continue in treatment?

(1) Initially, often this has to be court mandated or a parole stipulation.
(2) Parole as a carrot.
(3) Possibility of breach of probation - subsequent joint sentence as whip.
(4) Victim empathy.
(5) Intrinsic rewards - self-motivation/self-esteem.
(6) Advanced levels of treatment throughout the program.
(7) Reminder of consequences of reoffending, i.e. jail, hurting others.
(8) Focus on negative effects of past behaviour.
(9) Convince them they have a problem and convince them we have something of value to offer.

24. Please indicate any strategies you have developed for relapse prevention.

(1) We use all those described in D. R. Laws (Ed.) Relapse Prevention with Sex Offenders, Guilford Press, N.Y., 1989. All the authors are colleagues of mine.
(2) Clients develop their own pattern of behaviour, thoughts and feelings,

identify high risk situations, healthy coping alternatives.

(3) Assignments on a scenario where they could reoffend, including thoughts, feelings, behaviour and how they could stop it at different points in the cycle.

(4) Intensive contact with the psychologist and parole officer.

(5) Support groups; A.A. and A.C.O.A. groups in addition.

(6) To know their crime cycle and to use covert sensitization.

(7) Follow the Laws book on the subject.

(8) No particular strategy has been developed. Highlighting the deviant chain of events is essential and stressing the onus of seeking professional help prior to relapse. On an individual basis, concrete relapse prevention steps can be encouraged.

APPENDIX B

Child Sexual Abuse Needs Assessment

INSTRUMENTS

LIST OF INSTRUMENTS

A. Interview Guide for Children

B. Interview Guide for Adult Survivors of Child Sexual Abuse

C. Information on Children in Therapy

D. Information on Cases Currently in the System

E. Data Schedule

F. Case Problems

G. Survey of School Counsellors

H. Interview Guide for Familes

I. Sex Offender Survey

J. Sex Offender Program Survey

K. Interview Schedule for Therapists

L. Survey of Therapists and Counsellors

M. Case Worker Instrument Department of Health and Social Services

N. Agency Instrument

O. Law Inforcement Instrument, Municipal Police Departments, Royal Candadian Mounted Police Detachments

P. Justice Survey

Q. Case Requirements

INTERVIEW GUIDE FOR CHILDREN

ID NUMBER: ________

INTRODUCTION:

Who you are:
Research project: purposes ----> better helping system
why these interviews are important

Aims of the interview - Your perspective on all that's happened to you since the sexual abuse came out. (Not our intention to discuss the abuse itself. We know some basic facts about what happened but our aim is to talk about all that's happened since the abuse came out).

(1) what happened
(2) how other people around you responded/were with you
(3) your experience of different services, agencies, people who worked with you.
(4) how you felt in all this
(5) your ideas about what could make it better
(6) also . . . fill out some questionnaires . . . learn about you

Confidentiality and its limits (i.e. if we learn about additional offenses that haven't been reported.)

Control - uncomfortable questions

Questions for me?

BACKGROUND FACTORS:

I'd like to start by asking you a few questions about yourself, your family and your friends.

Age:

School:

Year:

Who's in your family?

or who lives at home with you?

Who do you get along with best in your family? (Easiest to talk to?)

Do you have some friends you feel close to? What do you like to do with them? Can you talk to them about important things?

DISCLOSURE:

PRESENT:

How did the sexual abuse finally come out? [who, when, how?] . . . (Why did you tell/trust that person?)

*A. How did the person you told (who learned) react/respond to your telling? (issues belief/blame, understanding, support/anger).

___ shock/horror
___ anger/hostility toward victim
___ anger/hostility towards offender
___ guilt over previous failure to protect victim
___ denial of victimization
___ denial of impact on victim
___ understanding/supportive toward victim
___ anxiety concerning impact on victim
___ anxiety concerning disruption of family
___ anxiety concerning physical violence from offender
___ conflict of loyalties between victim and offender
___ self-interest/self-defence/self-protection
___ withdrawal from crisis of disclosure
___ disbelief of victim
___ attempts to undermine victim's credibility
___ pressure on victim to suppress allegations
___ blaming victim
___ protective towards victim
___ obtained outside assistance
___ cooperative with outside authorities
___ other, specify ________________

How did you feel after you told them? (issues: fear ----> relief; safety ----> not safe)

What did that person do when they learned?

[reported to Social Services right away? Impact/effect of delays?]

*B. Why do you think you told when you did? Was something happening that made you decide? (What was going on in your life at the time?)

___ to obtain protection for herself
___ to obtain protection for other children
___ relief of guilt or shame
___ desire for more freedom from offender
___ resentment/anger/hostility towards offender
___ reaching puberty
___ fear of pregnancy
___ other, specify ____________________

PREVIOUS DISCLOSURES/PROCESS:

Did you ever try to tell anyone before? (who, when?)

*C. How did they respond to you?

___ shock/horror
___ anger/hostility toward victim
___ anger/hostility towards offender
___ guilt over previous failure to protect victim
___ denial of victimization
___ denial of impact on victim
___ understanding/supportive toward victim
___ anxiety concerning impact on victim
___ anxiety concerning disruption of family
___ anxiety concerning physical violence from offender
___ conflict of loyalties between victim and offender
___ self-interest/self-defence/self-protection
___ withdrawal from crisis of disclosure
___ disbelief of victim
___ attempts to undermine victim's credibility
___ pressure on victim to suppress allegations
___ blaming victim
___ protective towards victim
___ obtained outside assistance
___ cooperative with outside authorities
___ other, specify ___________________

How did you feel when you did . . . what was that like for you?

(Any other times? Response/reaction of others)

Did you ever try to let people know in other ways? (give off clues that you hoped people would notice?)

Were there any particular people you ever thought about telling before? (e.g. parent, brother, sister,friends, teacher, doctor . . .) Why do you think you couldn't? How do you think they would have responded?

*D. Were you worried about what would happen if you told? What did you worry about? [with family, friends]. [Did ______________ make you worry about what would happen if you told? What did he say about keeping it secret?]

___ favours/rewards
___ attention/affection
___ sexual pleasure
___ enhanced self esteem
___ loyalty to offender
___ fear of disbelief, blame or anger by third party (e.g. mother)
___ fear of offender being jailed
___ fear of offender harming himself/herself
___ fear of offender harming someone else
___ fear of victim being taken away from home
___ fear of physical violence from offender
___ actual physical violence from offender
___ other factors, specify ______________

Why do you think kids have so much trouble telling/don't tell?

What would make it easier for kids to tell? (What could adults do? Are they paying enough attention to what kids are trying to tell them?)

INVESTIGATION/INTERVENTION.

Talk about the time when people outside your family (e.g Social Services, police) started to become involved.

What happened after you told _________________? After they called Social Services, police? Who did you talk to? Where?

What was that like for you?

What were the social workers like with you? How did they react to you? (issues: belief, understand, support, on your side, blame/responsibility)

How were the police officers during that time? (issues ...?)

How did you feel about the questions they asked? Did you feel you had to tell them things you didn't want to?

How many times did you talk to them? How long did that go on? Effect on you?

Was there anyone else you had to talk to or see during that time? (Did you have a medical exam?)

What was that like for you?

During this time of the investigation, did you have a good understanding of what was happening? What did they (workers, officers) tell you? Did they give you (enough) information on why they were doing things (about what might happen)?

*E. If I asked you if this investigation upset you, would you say
yes or no?
|
|
|would you say ___a little ___ quite a bit ___ a lot?

What were the upsetting parts for you? The hardest parts? What hurt you the most?

What would have made it better for you? How could they make it better for other kids?

Who helped you the most during this time? (supported you/on your side?)

*F. I'd like to ask you about the feelings that you had during this time of the investigation. Which of the words on this list are good descriptions of how you felt during this time? (Which 3 or 4 seem to describe how you felt best?) Any other words that would describe it better? **ADJECTIVES** (Give a copy of the list for the child to keep with her. Explain that you'll be asking about it again several times.)

INITIAL CONSEQUENCES:

I'd like to know about the reactions of different people to you after you told (after the abuse came out) and what it was like for you with them?

FAMILY:

What happened in your family after you told? (after the abuse came out?)

*G. What was your mom like? How did she react? (issues: belief, understanding, support-on your side, responsibility/blame, isolation/rejection).

___ shock/horror
___ anger/hostility toward victim
___ anger/hostility towards offender
___ guilt over previous failure to protect victim
___ denial of victimization
___ denial of impact on victim
___ understanding/supportive toward victim
___ anxiety concerning impact on victim
___ anxiety concerning disruption of family
___ anxiety concerning physical violence from offender
___ conflict of loyalties between victim and offender
___ self-interest/self-defence/self-protection
___ withdrawal from crisis of disclosure
___ disbelief of victim
___ attempts to undermine victim's credibility
___ pressure on victim to suppress allegations
___ blaming victim
___ protective towards victim
___ obtained outside assistance
___ cooperative with outside authorities
___ other, specify ___________________

*H. How did your dad react?
(if not the offender)

___ shock/horror
___ anger/hostility toward victim
___ anger/hostility towards offender
___ guilt over previous failure to protect victim
___ denial of victimization
___ denial of impact on victim
___ understanding/supportive toward victim
___ anxiety concerning impact on victim
___ anxiety concerning disruption of family
___ anxiety concerning physical violence from offender
___ conflict of loyalties between victim and offender
___ self-interest/self-defence/self-protection
___ withdrawal from crisis of disclosure
___ disbelief of victim
___ attempts to undermine victim's credibility
___ pressure on victim to suppress allegations
___ blaming victim
___ protective towards victim
___ obtained outside assistance
___ cooperative with outside authorities
___ other, specify ________________

*I. Your brothers and sisters? (particular ones who were helpful/hurtful?)

___ shock/horror
___ anger/hostility toward victim
___ anger/hostility towards offender
___ guilt over previous failure to protect victim
___ denial of victimization
___ denial of impact on victim
___ understanding/supportive toward victim
___ anxiety concerning impact on victim
___ anxiety concerning disruption of family
___ anxiety concerning physical violence from offender
___ conflict of loyalties between victim and offender
___ self-interest/self-defence/self-protection
___ withdrawal from crisis of disclosure
___ disbelief of victim
___ attempts to undermine victim's credibility
___ pressure on victim to suppress allegations
___ blaming victim
___ protective towards victim
___ obtained outside assistance
___ cooperative with outside authorities
___ other, specify ___________________

Was there anyone in your family you could talk to about it?

(Extended family). Was there anyone else in your family whose reaction was important for you? Helped you or hurt you?

What was it like for you in your family then? Did telling Social Services/police make things better or worse for you? (issues: safety/protection, support, understanding).

FRIENDS:

What happened with your friends after you told?

Did you tell any of them? Did they know?

*J. How did they react? (issues: support/understanding;acceptance/rejection;belief)

___ shock/horror
___ anger/hostility towards offender
___ denial/disbelief of victimization
___ denial of impact on victim
___ anxiety concerning impact on victim
___ supportive/understanding toward victim
___ rejecting/avoidant of victim
___ conflict of loyalties between victim and offender
___ self-interest/self-defence/self-protection
___ withdrawal from crisis of disclosure
___ attempts to undermine victim's credibility
___ pressure/encouragement of victim to suppress allegations
___ blaming victim
___ protective towards victim
___ other, specify ___________________

Could you talk to any of your friends about it?

How did you feel with them after it came out? (after they knew?)

OTHERS:

What was it like with other people? . . . people in the neighbourhood, other kids at school, teachers, ...How did you feel with them?

Did you feel that they knew?

*K. How did they react? (issues: belief, understood what you'd been through, support-on your side, acceptance/rejection)

___ shock/horror
___ anger/hostility towards offender
___ denial/disbelief of victimization
___ denial of impact on victim
___ anxiety concerning impact on victim
___ supportive/understanding toward victim
___ rejecting/avoidant of victim
___ conflict of loyalties between victim and offender
___ self-interest/self-defence/self-protection
___ withdrawal from crisis of disclosure
___ attempts to undermine victim's credibility
___ pressure/encouragement of victim to suppress allegations
___ blaming victim
___ protective towards victim
___ other, specify ___________________

How did __________________ (the perpetrator) react to you?

Of all the people around you at the time, who (whose reaction) helped you the most?

Who (whose reaction) hurt you the most?

INTERVENTION:

What happened with you after the investigation? (With family? Offender?) What did they do? [offender leaves, child leaves, child/mother leave - see placement questions].

Was this what you wanted? What did you want?

What was this like for you? (issues: safety/protection, understanding, responsibility)

Did you have information on what was happening with ____________________ (perpetrator)? From whom?

*L. In the month or so after you told (after the abuse came out, after the investigation), which of the following words are good descriptions of how you felt with your family? **ADJECTIVES**

Did you continue to have contact with a social worker(s) as time went on? Same one, different one? Any other people from Social Services? (e.g. homemaker)

*M. How much contact did you have with her?

___ too little ___about right ___too much

Did she check up/follow up on what you needed, how you were getting along?

Here are a few more questions I'd like to ask you about your relationship with your social worker.(About the worker(s) with the most long term involvement).

*N. How would you describe your relationship with her?
___poor ___fair ___good ___very good

*O. How friendly was she with you? (How much did she seem to like you?)
___not at all ___a little ___somewhat ___ pretty much ___a lot

*P. How well did she understand your needs and problems?
___not at all ___a little ___somewhat ___ pretty much ___a lot

*Q. How much did you trust her (tell her things that were important to you?)
___not at all ___ a little ___somewhat ___ pretty much ___a lot

*R. How much did you feel that she was on your side (that she would go to bat for you?)
___not at all ___a little ___somewhat ___ pretty much ___a lot

*S. Which of the following words are good descriptions of how you felt with her?
ADJECTIVES

Is there anything else you would like to tell me about her?

PLACEMENT:

Where did you go to stay? Who lived there? What was your understanding of why you went there?

How did you feel about going there? Was it what you wanted?

Did you feel safe/protected there?

What were the workers like with you? (i.e. foster parents, group home workers, Anderson House staff) (issues: belief, understanding, support-on your side)

What was your family's reaction to your being there?

Did you have information on what was happening with ____________ (perpetrator)?

How long were you there?

Would you say you got home ___soon enough
___too soon
___about the right time

How did you feel with the other kids there? Did they know why you were there? Did it make a difference to them? (Issues: different/connected; alone/isolated)

*T. [If there for more than a month] Which of the following best escribes how you felt with the people there? **ADJECTIVES**

What were the best (most helpful) things that happened there?

The worst (least helpful, harmful?)

Did any of the other kids ever talk about having problems (with unwanted touch, with abusers) like the ones that brought you there?

INTERVENTION SUMMARY:

During this time (intervention) there were a lot of things going on and decisions being made about you.

Did the social workers involve you in making these decisions? Did they ask about what you thought or wanted? Did they act on what you wanted?

*U. How involved (asked) would you say you were?
___ not at all ___ a little ___ somewhat ___ very

Did workers tell you why they were making these decisions? Did you understand the reasons?

How carefully would you say workers explained these decisions to you?

*V. How well informed would you say you were about these decisions?
___ not at all ___ a little ___ somewhat ___very

Did you feel confused about what would happen? Could you predict what would happen or were decisions surprises to you? Were you worried about what would happen next?

*W. How confused would you say you felt?
___not at all ___a little ___somewhat ___ very

Were you given the advice and information that you felt you needed?

Who/what helped you the most during this time?

Who/what hurt you the most during this time?

What could have happened during this time to help you more? (How would you change it to make it better for you and other kids?)

THERAPY/COUNSELLING:

Some kids who have been sexually abused will go to talk to someone about it, a therapist or a counsellor . . . (someone besides the people from Social Services) . . . to help them work out their feelings about what happened. They might talk with a therapist/counsellor alone or with a group of other kids.

Did you ever go to talk with a therapist or counsellor? Who? Where? Context - individual or group?

When did you go? How many times (how often?)

How soon was this after the investigation? (when police and social workers talked with you after you told?) (Wish it were earlier? Too soon?)

Did you want to go? Was it hard to get there? (Did your parents/mom want you to go?)

Did any other members of your family go? Do you think they should have? (Did you want them to?)

What was counselling/therapy like for you? (Did you like going?)

Did you talk about the things that were important to you? (What did you talk about?)

(Group) What was it like to talk to other kids about yourself/your feelings? (Would you like to have talked to other kids?)

I'd like to ask you some of the same questions about your counsellor/therapist that I asked earlier about your social worker. What was she/he like? How did you get along? (What was it like to talk with her/him?)

*X. Would you describe your relationship with her/him as

___poor ___fair ___good ___very good

*Y. How friendly was she/he? How much did she/he seem to like you?

___not at all ___a little ___somewhat ___ pretty much ___a lot

*Z. How well did she/he understand your needs or problems?

___not at all ___a little ___somewhat ___ pretty much ___a lot (very well)

*AA. How much did you trust her? (to tell her things that were important to you?

___not at all ___a little ___somewhat ___pretty much ___a lot

*BB. How much did you feel that she was on your side?

___not at all ___a little ___somewhat ___ pretty much ___a lot

*CC. Did you ever feel that you had to tell her things when you really didn't want to?

___not at all ___a little ___somewhat ___ pretty much ___a lot

(Involved). Did she know and ask what you wanted? Did she act on what you wanted?

Did you understand what was going on?

Did you get the advice and information that you thought you needed?

Would you recommend her to another kid with problems?

*DD. Which of the following words are good descriptions of how you felt with her in therapy? **ADJECTIVES**

*EE. What was the effect of counselling on you?

___helped you ___made no difference ___hurt you
(a little or (a little or
a lot) a lot)

What was the most helpful thing about it? (best?)

What was the least helpful thing? What hurt? (worst thing)?

What would have made it better for you? How could you change it to make it better for other kids?

COURT PROCESS

Some kids may have to go to court to talk about what happened, or to get ready to go to court by talking with police. lawyers and others. Did you?

Can you tell me what this experience was like for you?

*FF. Would you say that your experience with court upset you? ___yes ___no

If yes,

1	2	3
___a little	___somewhat	___a lot

*GG. Which of the following parts were upsetting to you? How much?

a.	police investigation for court	1	2	3
b.	victim impact statement	1	2	3
c.	waiting for court (i.e. all the time after the investigation while waiting to go to court)	1	2	3
d.	preparation for court with crown prosecutor	1	2	3
e.	testifying in court	1	2	3

Let's return to talk a little more about your feelings about each of these parts and some of the people involved.

Investigation:

How many interviews/interviewers?

Context? (when, where, over what period of time?)

How did you feel about the questions they asked?

What were the officers like? (issues: belief; understand; support-on your side).

Waiting/preparing for court:

How long did you wait for the trial to go on?

What was that like for you? Worry (how much?)

What were your interviews with the Crown Prosecutor like? (issues: belief, support; understanding). (How many times?)

Did anyone help you to get ready for court? Who? How? What did they do?

*HH. Was that helpful for you? ___not really ___ a little ___some ___a lot
What about it helped?

Testifying in court:

How did you feel about going to court?

Did you understand what was going on? Confused? Scared?

How did the people in court respond to you? What were they like? (How did you feel with them?) (issues: belief; understand; support; responsibility/blame)

Crown?

Judge?

Defence?

How did you feel about the questions they asked you?

What was it like to tell your story in court in front of all those people?

Post court:

What happened in the case? How did you feel about the verdict/sentence? (Was it fair? What did it mean to you?)

What would have been fair?

How did you feel afterwards? Were you glad that you had gone to court . . . or do you wish that you never had? Why?

What/who helped you the most to get through the court/legal process?

What was the most difficult/worst part of the whole experience of court?

*II. When you think about this whole process of court . . . the investigations, waiting, getting ready, testifying in court. . . which of the following words best describes how you felt?

ADJECTIVES

*JJ. When you think about this whole process of court and its effect on your life, would you say it

___helped you (a little or a lot)	___made no difference	___hurt you (a little or a lot)

If you could make changes to the whole court process to make it better for you and for other kids, what would you do?

SUMMARY:

I'd like to ask you now to think back over all that you've been through since you told about the sexual abuse (review steps: investigation, interviewing, intervention, placement, therapy, court preparation, appearances, living in your family, with friends, in your neighbourhood) . . .

What's been the most difficult part of all this for you? What's hurt you the most? (What made it difficult, hurtful?)

What's been the most helpful, positive part/experience? (What made it helpful?)

I'd also like you to think back over all of the different people you've come in contact with who may have known about the sexual abuse. We'd like to know if the way other people acted with you helped you or hurt you (or made things worse for you). Helped could mean a number of things... that they understood you, believed you or protected you, that you felt safe with them or thought they were on your side, or that you could trust them to still care about you or to try to make things better. Hurt could mean many things too... someone can make things worse by not believing you, or blaming you for what happened, not protecting you or making it safe for you, rejecting you or acting in ways that may make you feel alone or guilty or just bad. For each person, I'll ask you if the way they acted was really helpful, helped a little, didn't really help at all, made things a little worse or made things a lot worse. Most kids haven't been involved with all these people during this time, so you can tell me if that's true for any of them.

	really helped (helped a lot)	helped a little	didn't really help	made things a little worse	made things lot worse
*KK. FAMILY:					
Mother	______	______	______	______	______
Father	______	______	______	______	______
Brothers/sisters (generally)	______	______	______	______	______
______________	______	______	______	______	______
______________	______	______	______	______	______
Relatives					
	______	______	______	______	______
______________					
______________	______	______	______	______	______
*LL. FRIENDS:					
______________	______	______	______	______	______
______________	______	______	______	______	______
Other kids at school	______	______	______	______	______

*MM. OTHER ADULTS: Were there other adults whose reaction was important to you (either positive or negative?)

Teacher	______	______	______	______	______
Doctor	______	______	______	______	______
Minister	______	______	______	______	______

*NN. "WORKERS"

Social service investigators (intake) ______ ______ ______ ______ ______

Police ______ ______ ______ ______ ______

Counsellor/therapist ______ ______ ______ ______ ______

Case worker ______ ______ ______ ______ ______

Homemaker ______ ______ ______ ______ ______

*OO. COURT:

Crown prosecutor ______ ______ ______ ______ ______

Victim services ______ ______ ______ ______ ______

Judge ______ ______ ______ ______ ______

Defence lawyer ______ ______ ______ ______ ______

*PP. PLACEMENTS:

Anderson House workers ______ ______ ______ ______ ______

Foster parents ______ ______ ______ ______ ______

Foster children ______ ______ ______ ______ ______

Group home workers ______ ______ ______ ______ ______

Other group home residents ______ ______ ______ ______ ______

Any other important person (helped or hurt) that I left out? ______ ______ ______ ______ ______

When you think of all these people and the different ways they helped... who did you feel the most safe and protected with? (that you trusted to look after you?)

Who seemed to understand your needs and what you'd been through most? Most on your side?

Who seemed to like you the most for just being yourself?

When you think of the different ways that people made things worse... who did you feel the most guilty and bad with? (who blamed you?)

Who couldn't you trust to help you? (feel unsafe). (Who let you down?)

Who didn't seem to like you? Rejected you because of what happened?

Who made you feel helpless? (Or scared?)

*QQ. When you think of all the people (like workers, police, therapists, Crown Prosecutor) who became involved in your life since the abuse came out, and all you've gone through (e.g. investigation, interviews, therapy, placement, court), would you say it has all

___helped you (a little or a lot)	___didn't really help (made no difference)	___made things worse (a little or a lot)

Knowing what you know now, would you tell again? (Did telling make things better?) Why not?

If there were 3 things that you could change about this whole system of responding to kids who have been sexually abused, what would you change? What would make it better for other kids?

1.

2.

3.

What advice would you have for other kids who've had this happen to them? What should they do?

What advice would you have for people trying to help kids who've had this happen? What should they do?

Is there anything else about all this that you'd like to tell me about? That you feel we should know?

What's it been like for you to answer these questions today? Do you have any suggestions for how we might talk to other kids so that they can tell about their experiences and feel comfortable?

Any other questions for me? Would you like to receive a summary of the results of these interviews?

ADJECTIVES

____ accepted
____ angry
____ ashamed
____ believed
____ blamed
____ cared for
____ confused (mixed up)
____ different
____ dirty
____ guilty (or bad)
____ helpless
____ informed
____ isolated (or alone)
____ mistrustful
____ liked
____ protected
____ rejected
____ safe
____ scared
____ strong
____ supported (on your side)
____ trusting
____ understood

INTERVIEW GUIDE FOR ADULT SURVIVORS OF CHILD SEXUAL ABUSE

ID NUMBER: _______________

INTRODUCTION:

Who you are:

Research project:	purposes and aims. purpose of interviews - how your description of your own experience can help us learn more about what abused children and adult survivors need.
Areas of material:	1. Background information 2. Description of abuse, your family at the time and how you coped with it. 3. Disclosure process: Obstacles and difficulties with disclosure and reporting. 4. Effects of child sexual abuse on your life - as a child, as an adult. 5. Your experience of coming to terms with your abuse...Healing...Role of therapy, support, response of others...what's helpful/nonhelpful. 6. Your ideas about what children need to recover, to avoid victimization.

Confidentiality:

Control of interview - uncomfortable questions... Questions for me?

A. BACKGROUND:

Age:

Current work/school:

Current family situation/children:

How you came to the project. What made you decide to volunteer?

AS A CHILD:

How would describe your family as a child? Who lived at home? Number of boys, girls? Different expectations/roles for boys and girls - different chores, accepted behaviours?

Your parents... what did your father do? Mother's work?

Who was in charge in your family? How did things get done? What was discipline like?

Were members of your family close to each other? Understanding and supportive? Who did you feel closest to?

Were members of your family affectionate toward each other? Attitudes about touching? What was your family's attitude about sex?

Describe your parent's relationship as best you can.

How did your parents/family get along in the community? (e.g. were they isolated? Did they have friends?)

Did you have close friends as a child?

B. AT THE TIME OF THE ABUSE:

In the next series of questions, we would like to ask you about your experience of sexual abuse as a child and some of the feelings and thoughts that you had about it then in order to best understand sexual abuse from the point of view of the women/men who have lived with it. (Offer to show the questions to her/him). If you aren't comfortable with that or would prefer not to discuss such feelings, we would ask you to answer several specific questions about the abuse (such as your relationship with the offender, how long it went on, your age at the time) so that we have a clearer idea of what you're referring to and can better understand your experience. How would you prefer to approach this? [Use either the questions below or the specific questions following page 4).

What happened to you? Who abused you? How old were you when it began? How long did it go on? How often? Ever abused by others?

How did you think about it at the time? How did you realize it was abuse rather than something that happened to everyone?

At the time, do you remember why you thought it was happening? Why do you think now it began or took place? What made you vulnerable? Any other kids in the family?

What did the abuser say to you about what he was doing to you? How did he talk about it? Explanations? Threats? Offered favours?

How did the sexual abuse make you feel? What were your reactions at the time?

Feelings/reactions about self?

To/about/with perpetrator?

To/about/with family?

To/about/with friends?

How did you function at the time of the sexual abuse? How did you cope with it? What effect did it have on any aspects of your life? (e.g. school, relations with others, problems)

ASK THIS FOR ALL RESPONDENTS:

How would you describe the child you became because of your experience of sexual abuse?

SPECIFIC QUESTIONS:

1. How old were you when the abuse began?

2. What was your relationship with the perpetrator?

3. How often did the abuse happen?

4. How long did the abuse continue?

5. If you thought of the sexual abuse as ranging in seriousness (or severity or obtrusiveness) along a continuum from less serious to extremely serious, how would you characterize your experience?

1	2	3	4	5
not very serious (severe)	somewhat serious (severe)	moderately serious (severe)	very serious (severe)	extremely serious (severe)

C: DISCLOSURE/OBSTACLES:

We know that the process of disclosure is a difficult one, a gradual one that children and adult survivors may try to communicate their abuse or try to stop it in a variety of ways. We want to learn about your experience with this process.

When did the abuse stop? How?

Did you tell someone that you were being abused? What made you choose/trust that person? What did you say?

How did that person respond? What did they say/do? Why do you think they responded that way?

- ___ shock/horror
- ___ anger/hostility toward victim
- ___ anger/hostility towards offender
- ___ guilt over previous failure to protect victim
- ___ denial of victimization
- ___ denial of impact on victim
- ___ understanding/supportive toward victim
- ___ anxiety concerning impact on victim
- ___ anxiety concerning disruption of family
- ___ anxiety concerning physical violence from offender
- ___ conflict of loyalties between victim and offender
- ___ self-interest/self-defence/self-protection
- ___ withdrawal from crisis of disclosure
- ___ disbelief of victim
- ___ attempts to undermine victim's credibility
- ___ pressure on victim to suppress allegations
- ___ blaming victim
- ___ protective towards victim
- ___ obtained outside assistance
- ___ cooperative with outside authorities
- ___ other, specify ________________

What did that person do when they learned? How did you feel when that happened?

Did you ever try to tell anyone else before this? (Who? When?) How did they respond to you? What did they do when they learned?

___ shock/horror
___ anger/hostility toward victim
___ anger/hostility towards offender
___ guilt over previous failure to protect victim
___ denial of victimization
___ denial of impact on victim
___ understanding/supportive toward victim
___ anxiety concerning impact on victim
___ anxiety concerning disruption of family
___ anxiety concerning physical violence from offender
___ conflict of loyalties between victim and offender
___ self-interest/self-defence/self-protection
___ withdrawal from crisis of disclosure
___ disbelief of victim
___ attempts to undermine victim's credibility
___ pressure on victim to suppress allegations
___ blaming victim
___ protective towards victim
___ obtained outside assistance
___ cooperative with outside authorities
___ other, specify __________________

Your feelings about that?

Did you ever try to let people know in other ways? Give off clues through your behaviour that you hoped others would notice?

What was the effect on you, your relation with your family of having told?

[If no disclosure] What do you think stopped you from telling anyone (or anyone else?). What were you worried/frightened about? (Threats?)

Were there particular people you thought about telling? (e.g. parent, sister, teacher, etc?) Why do you think you couldn't?

Do you think anyone else knew of your abuse without your having directly told them? Why do you believe so? Why do you think they didn't act?

What did you want someone to say or do to help you? Was there someone in particular? What would have helped to stop the abuse?

Was your abuse ever reported to a social service agency or to the police?

If yes, include the following questions about investigation, intervention, court and therapy. If no go to the questions on adult disclosure on page 12).

What happened (in the investigation) after your abuse was reported?

Do you remember who you had to see to talk to at that time (social workers, police, doctors)? What were they like with you (issues: belief, understanding, support, blame/responsibility).

What was this whole process of investigation like for you?

Would you describe the investigation as upsetting to you?

If yes, would you describe it as
___ somewhat upsetting
___ moderately upsetting
___ very upsetting
___ extremely upsetting

What were the most upsetting aspects for you? What hurt you the most?

(INTERVENTION)

What happened in your life after the investigation? What did the workers (or police) do to intervene? (offender leaves, child leaves, mother and child leave). Were you sent to live somewhere else?

What was this like for you? (issues: safety, understanding/support, responsibility). Was this what you wanted . . . what you felt was best for you? Did the workers involved in your life consult with you, ask you what you wanted, explain their decisions to you? (self-control issues).

What happened to the offender?

What happened with your family? What was this like for you (concerns about family reunification/separation)?

(COURT):

Did you ever have to go to court to testify, or prepare for court by talking with the police, crown prosecutor or other workers?

What was that experience like for you?

Would you describe your experience with court as upsetting?

If yes, how upsetting?
___ somewhat upsetting
___ moderately upsetting
___ very upsetting
___ extremely upsetting

What were the most upsetting and difficult aspects of this for you? (e.g. police investigation, waiting/preparing for court, testifying in court)

How did the people involved in the legal/.court process respond to you (i.e. police, crowns, lawyers, judges). What were they like with you?

What happened in the case? How did you feel about the outcome? How do you feel about it now?

(THERAPY/SUPPORT):

When you were a child, did you ever go to see a therapist or counsellor to help you deal with the experience of being abused? What was this experience like for you? How did they respond to you?

How would you describe the effect that counselling you had as a child had on your life?

1	2	3	4	5	6	7
extremely positive/ helpful	very positive/ helpful	somewhat positive/ helpful	neither positive nor negative/ little effect	somewhat negative/ harmful	very negative/ harmful	extremely negative/ harmful

What were the most helpful/positive aspects of it?

What were the most negative/harmful aspects of it?

When you were a child, who were the (other) people who helped and supported you most in dealing with being abused?

"ADULT DISCLOSURE"

With whom have you been able to discuss the abuse? When did you begin to speak about it to others? Why did you decide to? What has her/his response been like?

What has been the effect on you of telling others about your abuse?

What have been the barriers for you in speaking about it to others? Who else would you have wanted to tell?

Why do you think kids don't tell about their abuse? What would make it safe for children to disclose? Do you think it is safe now (compared to when you were a child?) Why? Why not?

D. EFFECTS ON YOU:

In your own words, how would you describe the effects/impact that the sexual abuse has had on your life? Did your feelings change over time? How does being a survivor of child sexual abuse affect your life today?

We'd like to learn about how you think being abused has affected particular areas of your life.

The social/interpersonal aspect of your life (e.g. issues of isolation, mistrust, closeness, expectations in relationships about what other people want from you, in friendships)

Feelings/relations with men?

Feelings/relations with women?

The psychological/emotional aspect of your life, (e.g particular feelings such as absence/blunting of feeling, being very emotionally reactive, issues with particular feelings such as anger)

Are there any particular problems/symptoms/illnesses you have or have had that you feel are related to the abuse?

Psychological/behavioural (e.g. dissociation, eating disorders, anxiety, alcohol/drug problems)

Physical (e.g. headaches, pain)

Your life with your family. . .

The family your grew up in (i.e. family of origin) (e.g. closeness, distance, separation, feelings about particular people, toward you . . . with mother, father, brothers, sisters

Current family (if applicable) . . . relations with spouse, with children, concerns about abuse.

The sexual aspect of your life (e.g fears, confusions, dislikes, level of desire, sexual preference) . . . effect on your current sexual relationship.

Your whole sense of yourself as a person (e.g. your self concept, feelings about yourself and the kind of person you are, sense of power/powerlessness, self control, worth)

When you think of the overall effect that being sexually abused has had on your life, how would you describe it on a continuum from positive to negative?

1	2	3	4	5	6	7
extremely positive	very positive	somewhat positive	neither positive nor negative	somewhat negative	very negative	extremely negative

E. THERAPY/HEALING/RECOVERY:

We'd like you to describe, as best you can, your own process of coming to terms with (coping with) your abuse. What has your process of healing/recovery been like?

When did it begin (i.e. awareness/recall). . . was there a time when you didn't remember the abuse? What brought the memories back? What was that like for you?

How completely do you remember now? How important has that been for you in your recovery process?

Who were the people and/or what have been the experiences that have been most important/helpful to you in coming to terms with your abuse?

Your therapy? (if applicable). Who? When did you begin? Frequency/length of sessions? Individual/group?

What led you to decide to seek therapy?

What has your experience in therapy been like? Has it been what you wanted? How directly focused/concerned with the sexual abuse? What goes on? How structured or nondirective? Who controls/directs what happens in therapy - your comfort with that? Who set the pace? Were there issues your therapist introduced that you didn't wish to discuss? Were there issues you thought your therapist should have introduced, but didn't?

What have been the most helpful aspect of your therapy experience? What's helped you the most? What are the most important aspects of your therapy/issues you've dealt with?

What aspects of your experience did your therapist seem to understand/deal with well?

What have been the least helpful or the most harmful/negative aspects of your therapy experience? What's hurt you the most?

What aspects of your experience did your therapist not understand/deal with well? Have the most difficulty with?

How would you describe the effect that therapy has had on your life on the following scale?

1	2	3	4	5	6	7
extremely positive/ helpful	very positive/ helpful	somewhat positive/ helpful	neither positive nor negative/ little effect	somewhat negative/ harmful	very negative/ harmful	extremely negative/ harmful

What effect has your therapy/healing had on other aspects of your life (e.g relationships with friends, partners). . . how much "space" in her life is directed/concerned with her healing/therapy?

What would you describe as the most difficult aspects of this healing process for you?

What are the most important things that adult survivors require to recover from sexual abuse? What advice would you give to those who work with adult survivors?

From your perspective, how would you describe the services currently available for adult survivors of sexual abuse? (i.e. availability, quality, nature of therapy - individual, group)? What's needed?

[If therapy was individual] What do you think it could have been like for you to be in a therapy group with other survivors?

Other sources of support:

Have you been in a support group (or a therapy group?) [If YES, then return to ask the questions relevant to therapy].

How has being in a group helped you, i.e. what has been the impact of talking with other survivors, what have group members provided you with? Do you prefer it to individual work?

Are there other people who have been important to you in your process of recovery? Are you able to find others who listen and will talk with you when you want to talk about it? (Support issues?)

Were you ever in therapy previously (or receive treatment for a psychological/psychiatric/drug problem?) Was your sexual abuse ever discussed?

If yes, what was the response to it? How did your therapist deal with it?

If no, why not?

F. KEY INFORMANTS:

We would also like your advice on how best to respond to and help sexually abused children (which is the major focus of this needs assessment). We would like to learn about your perceptions of what they need at different steps in the intervention process.

Disclosure:

Why do you think children don't disclose their sexual abuse? Is it safe? Is it safer than when you were a child? Do children disclose or communicate their abuse in ways that adults don't see (or ignore)?

What would make it safe? What would children need in order to be able to disclose their abuse?

Investigation/Intervention:

(Are you familiar with what happens once a child discloses? Do you have any opinions you would like to share about it?)

What's your perception of the effect that investigation has on most children? What's it like for children? (Are there ways to avoid any negative aspects she identifies?)

What do children need in the time immediately following their disclosure? What would help them the most? Where do they need to be? Most important sources of support?

In your view, what are the problems/what's harmful for kids about what happens in investigation and intervention?

Court:

What's your view of the impact of court on most sexually abused children? How well does the legal process/court respond to children? What problems do you see in the court process for sexually abused children?

Do you think that court plays a role in the healing process for sexually abused kids? Why (or why not?) - i.e. what role? Should kids go to court?

What's your perspective on how Island courts have responded to/handled sexual abuse cases? . . . (court process, sentencing). Do you think this has any impact on children's decision to disclose?

What's needed in the court process (to solve the problems you've identified)? To make it better for children? How ought courts respond to offenders?

Therapy/healing:

What are the most important things that children require to heal/recover from sexual abuse (e.g. role of therapy, time, groups, self-help, ongoing support, self direction and control)?

What advice would you give to therapists/counsellors about how to help abused children? What do they need to know?

What advice would you give to sexually abused children? What would you like to pass on to them from what you've learned from your experience?

Prevention:

In your view, what do we need to do in order to stop sexual abuse from happening? Why do you think it happens? What needs to change?

G. ENDING:

Is there anything else you would like to tell me about your experience that we haven't discussed?

What's it been like for you to speak with me about your experience today? Do you have any suggestions for how we might talk to other survivors in ways that would be better?

Any other questions for me? Would you like to receive a summary of the results of these interviews when they're completed?

INFORMATION ON CHILDREN IN THERAPY

rev. 01/02/91

This form is designed to collect information about children in therapy, both present and past. The form is worded in the past tense, but if you are answering it for a child whom you are presently seeing, please answer the questions in the present.

ID NUMBER: ______________________________

DATE: ______________________________

AGENCY: ______________________________

ABOUT THE CHILD:

1. One might conceptualize sexual abuse as ranging in seriousness along a continuum from less serious to very serious. From your experience with sexually abused children, please rate the seriousness of the effects of the sexual abuse on this child, using the following scale.

A rating of 1 indicates that the present case is similar to other cases of sexual abuse that you would consider to be less serious. A rating of 4 should indicate the present case is similar to the average case of sexual abuse for which you come in contact. A rating of 7 should indicate that the sexual abuse was extremely serious, much more serious than your average case.

1	2	3	4	5	6	7
least serious			moderately serious			extremely serious

2. How would you describe the impact the child's sexual abuse has had on her/his life?

___ negative impact ___ no impact ___ positive impact

Please rate the degree of impact the child's sexual abuse has had on her/his life.

1	2	3	4	5	6	7
a little			moderate			extreme

3. Generally speaking, how emotionally disturbed or upset was the child by her/his sexual abuse experience?

7	6	5	4	3	2	1
extremely			moderately			not at all

4. Please check the 3 or 4 words or phrases listed below that best describes the child's feelings and experiences at the time you were seeing her/him.

___ accepted
___ angry
___ ashamed
___ believed
___ blamed
___ cared for
___ confused
___ different
___ dirty
___ guilty
___ helpless
___ informed
___ isolated
___ liked
___ mistrustful
___ protected
___ rejected
___ safe
___ scared
___ strong
___ supported
___ trusting
___ understood

5. Generally speaking, how would you characterize her/his overall psychological adjustment?

7	6	5	4	3	2	1
very good			fair			very poor

ABOUT THE CHILD'S FAMILY AND SUPPORT SYSTEM:

6a. How would you characterize the mother's response to disclosure? If there was no mother in the home or there was little contact with the mother, please check "not applicable".

___ not applicable

1	2	3	4	5	6	7
unsupportive to victim; rejecting; angry; blaming victim; protective of offender; denying abuse		inconsistent support to victim; ambivalence towards victim; changes perspective; some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

6b. If the father was not the offender, how would you characterize the father's response to disclosure? If the father was the offender, was not available or had little contact please check "not applicable".

___ not applicable

1	2	3	4	5	6	7
unsupportive to victim; rejecting; angry; blaming victim; protective of offender; denying abuse		inconsistent support to victim; ambivalence towards victim; changes perspective; some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

7a. How would you characterize the level of supportiveness the mother provided to the child? If the mother was not in the home or there was little contact with her, please check "not applicable".

___ not applicable

1	2	3	4	5	6	7
unsupportive to victim; rejecting; angry; blaming victim; protective of offender; denying abuse		inconsistent support to victim; ambivalence towards victim; changes perspective; some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

7b. If the father was not the offender, how would you characterize the level of supportiveness he provided to the child? If the father was the offender, was not available or had little contact please check "not applicable".

___ not applicable

1	2	3	4	5	6	7
unsupportive to victim; rejecting; angry; blaming victim; protective of offender; denying abuse		inconsistent support to victim; ambivalence towards victim; changes perspective; some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

Confidential:

8. Please identify the persons (by indicating their relationship to the victim) in the victim's life since the disclosure of the sexual abuse who provide her/him with the most support, understanding and acceptance.

____________________________ ____________________________

____________________________ ____________________________

9. If you consider all of the persons involved in the child's life since the disclosure of the sexual abuse (family, friends, professionals, etc), how would you characterize the level and quality of support available to her/him?

1	2	3	4	5	6	7
minimal support			moderate level of support			high level of support

ABOUT THERAPY/RELATIONSHIPS:

10. Date client was referred for therapy. ____________________

11. Referral source. ______________________________

12. Date therapy began. ____________ Date therapy ended. ______________

13a. Type of therapy
___ individual
___ group (nature of group __________________)
___ family (please specify who participated, (________
____)

13b. Number of sessions. ____ Individual ____ Group ____ Family

13c. Average length of sessions. ____ Individual ____ Group ____ Family

14. Frequency
___ once a week
___ once every two weeks
___ once a month
___ other, please specify ______________________

14a. How often did the child (family) miss or cancel appointments?
___ rarely (10% or less of the scheduled sessions)
___ occasionally (10-30% of the sessions)
___ frequently (30-50% of the sessions)
___ very frequently (more than 50% of the sessions)

14b. Did the client (family) terminate therapy prematurely (i.e. do you believe they "dropped out")? ___ yes ___ no

15. How motivated was the child in therapy?

1	2	3	4	5	6	7
not at all motivated			moderately motivated			very motivated

16. How cooperative was the non-offending parent(s) in the therapy process?

1	2	3	4	5	6	7
highly resistive		somewhat resistive		somewhat cooperative		highly cooperative

17a. What were the major goals in therapy with this child? ______________________
____
____
____

17b. How well do you think these goals were met?

1	2	3	4	5	6	7

not at all	moderately well	very well

18. What were the major problems and difficulties for this child arising from her sexual abuse experiences?

19. What were the major difficulties and issues in therapy for this child as a result of her/his sexual abuse?

20. What was your assessment of this child's progress in therapy? (i.e. how much did therapy help her/him to resolve the major clinical issues mentioned above?)

1	2	3	4	5	6	7
no progress		some progress		considerable progress		a great deal of progress

21. If you answered question #20 with a rating of 1, 2, or 3, what would you identify as the major obstacles to therapy?

___ motivation of the child
___ motivation of the family
___ therapist's level of background knowledge/training in sexual abuse
___ minimal experience with sexual abuse cases
___ insufficient time available for therapy with the victim
___ limited therapy resources available for other family members
___ victim's issues/anxiety with the court process
___ problems with other aspects of the intervention, please specify, ______
____
___ family/home situation (please specify, ______________________)
___ other, (please specify, ______________________________)

22. How would you characterize the relationship you had with this child?

7	6	5	4	3	2	1
excellent		good		fair		poor

23. How would you characterize the feelings you had about this child?

7	6	5	4	3	2	1
very positive		somewhat positive		somewhat negative		very negative

24. How comfortable were you with this child? (How much could you be yourself?)

7	6	5	4	3	2	1
very comfortable		somewhat comfortable		somewhat uncomfortable		very uncomfortable

25. How well do you feel you understood the child's needs and problems?

7	6	5	4	3	2	1
extremely well			moderately			not at all

26. How much do you think the child trusted you?

7	6	5	4	3	2	1
very much			moderately			not at all

27a. How would you characterize your relationship with the mother? If the mother was not in the home or you had little or no contact with her, please check "not applicable".

7	6	5	4	3	2	1
excellent		good		fair		poor

27b. (If the father was not the offender). How would you characterize your relationship with him? If the father was the offender, was not available or you had little or not contact with him, please check "not applicable".

___ not applicable

7	6	5	4	3	2	1
excellent		good		fair		poor

28a. How much do you think the mother trusted you? If the mother was not in the home or if you had little or not contact with her, please check "not applicable".

___ not applicable

7	6	5	4	3	2	1
very much			moderately			not at all

28b. (If the father was not the offender). How much do you think the father trusted you? If the father was the offender, was not available or you had little or no contact with him, please check "not applicable".

___ not applicable

7	6	5	4	3	2	1
very much			moderately			not at all

29. Children who have been sexually abused will experience a number of aspects of the intervention system with several agencies. From your perspective as a therapist, please rate the effect of each of these intervention processes with this child on the following scales. Rate only those experiences that the child has had.

A. How emotionally upsetting was each experience for the child at the time?

	not applicable	not at all upsetting			moderately upsetting			extremely upsetting
investigation by Child and Family Services	0	1	2	3	4	5	6	7
investigation by police	0	1	2	3	4	5	6	7
intervention decisions victim alone removed from home	0	1	2	3	4	5	6	7

victim sent to foster home	0	1	2	3	4	5	6	7
victim sent to group home	0	1	2	3	4	5	6	7
victim sent to temporary care with other relatives	0	1	2	3	4	5	6	7
victim and mother removed from home	0	1	2	3	4	5	6	7
offender removed from home	0	1	2	3	4	5	6	7
offender returned to home	0	1	2	3	4	5	6	7
other, ____________ ______________________	0	1	2	3	4	5	6	7
therapy	0	1	2	3	4	5	6	7
court								
awaiting court	0	1	2	3	4	5	6	7
preparation for court (e.g. by Crown, Victim Services, Social Services)	0	1	2	3	4	5	6	7
testifying in court	0	1	2	3	4	5	6	7
court verdict/sentence	0	1	2	3	4	5	6	7
other, please specify ______________________	0	1	2	3	4	5	6	7

B. What was the overall effect each experience had on the child? (We are asking both questions since an emotionally upsetting event could possibly have an ultimate positive or therapeutic effect).

	not applicable	very positive	slightly positive	somewhat positive	neither positive nor negative	somewhat negative	slightly negative	very negative
investigation by Child and Family Services	0	1	2	3	4	5	6	7
investigation by police	0	1	2	3	4	5	6	7
intervention decisions								
victim alone removed from home	0	1	2	3	4	5	6	7
victim sent to foster home	0	1	2	3	4	5	6	7
victim sent to group home	0	1	2	3	4	5	6	7
victim sent to temporary care with other relatives	0	1	2	3	4	5	6	7
victim and mother removed from home	0	1	2	3	4	5	6	7
offender removed from home	0	1	2	3	4	5	6	7
offender returned to home	0	1	2	3	4	5	6	7
other, ______________ __________________________	0	1	2	3	4	5	6	7
therapy	0	1	2	3	4	5	6	7

court								
awaiting court	0	1	2	3	4	5	6	7
preparation for court (e.g. by Crown, Victim Services, Social Services)	0	1	2	3	4	5	6	7
testifying in court	0	1	2	3	4	5	6	7
court verdict/sentence	0	1	2	3	4	5	6	7
other, please specify ______________	0	1	2	3	4	5	6	7

28. Please add other comments you would like to make about this child, the family and the therapy.

29. Please add other comments you would like to make about this child, the family and the entire intervention process.

This form is to be completed on all cases that have been in the system 4-6 weeks.
T2 information.

INFORMATION ON CASES CURRENTLY IN THE SYSTEM

ID NUMBER:____________

FAMILY:

For the purposes of this study, "family" will be defined as the unit in which the child lives.This could mean any combination of parents, step-parents, grandparents or other relatives, as well as foster care or a group home in an ongoing basis not related to the sexual abuse. Please refer to this definition in all questions pertaining to family.

1. DEMOGRAPHIC INFORMATION:

Number of people in the family____ Number of brothers_____

Number of sisters_____

Marital status
___nuclear
___stepfamily
___one parent, one partner
___one parent, no partner
___one parent, several partners
___common law
___other, ______________________

Education of mother
___< grade 7
___7-9
___10-12
___some university
___university degree
___graduate degree
___technical/trade school
___training (i.e. nursing)
___other, specify ________________
___don't know

Occupation of mother ________________________

Education of father
___< grade 7
___7-9
___10-12
___some university
___university degree
___graduate degree
___technical/trade school
___training (i.e. nursing)
___other, specify ____________________
___don't know

Occupation of father ____

Religion of family
___Roman Catholic
___United
___Presbyterian
___Anglican
___Baptist
___Mormon
___Pentecostal
___Salvation Army
___Jewish
___other, specify ______________________
___don't know

Family income
___<9,999
___10,000-19,999
___20,000-29,999
___30,000-39,999
___40,000-49,999
___50,000-59,999
___60,000-69,999
___>70,000
___don't know

2. PREVIOUS AGENCY CONTACTS OVER THE PAST 4 YEARS:

Agency	Victim	Date	Family	Date
Child and Family Services	___Yes ___No	________	___Yes ___No	________
Community Mental Health	___Yes ___No	________	___Yes ___No	________
Catholic Family Services	___Yes ___No	________	___Yes ___No	________
Protestant Family Services	___Yes ___No	________	___Yes ___No	________
Prince County Family	___Yes ___No	________	___Yes ___No	________
Psychiatrist /psychiatric unit of the hospital	___Yes ___No	________	___Yes ___No	________
Psychologist /private/social worker/other therapist	___Yes ___No	________	___Yes ___No	________
Addiction Services	___Yes ___No	________	___Yes ___No	________
School/guidance	___Yes ___No	________	___Yes ___No	________
Legal system	___Yes ___No	________	___Yes ___No	________
Doctor (most recent visit)	___Yes ___No	________	___Yes ___No	________
Hospital (QEH, Prince County, Kings County, etc) (in the last year)	___Yes ___No	________	___Yes ___No	________
Hillsborough Hospital	___Yes ___No	________	___Yes ___No	________

Other, specify.

____________________	___Yes ___No	_______	___Yes ___No	______
____________________	___Yes ___No	_______	___Yes ___No	______

3. How was the sexual abuse first discovered?______________________________

____

Who first discovered it?____

REACTIONS AND SUPPORT:

4. What was the initial reaction of the person to whom disclosure was made? (Check as many as apply).

___shock/horror
___anger at the victim
___anger at the offender
___denial of the problem
___disbelief of victim
___cooperative with outside authorities
___withdrawal from the crisis
___fear of the offender
___rationalization of behaviour
___blaming the victim
___concern for the victim
___pressing charges
___other, specify ______________________

5. How supportive is/are the non-offending parent(s) to the victim at disclosure?

____

1	2	3	4	5	6	7
unsupportive to victim, rejecting, angry, blaming victim, protective of offender, denying abuse		inconsistent support to victim;ambivalence towards victim; changes perspective; some anger at offender;		generally supportive; angry at offender; upset re abuse sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

6. What is the nature of the marital relationship at disclosure?

___ not applicable

1	2	3	4	5	6	7
destructive; couple fused; at war or isolated		overt marital difficulties or both partners dissatisfied		basically satisfactory with some problems		mature; warm; supportive relationship

7. What is the nature of the relationship between the victim and mother/caregiver?

___not applicable

1	2	3	4	5	6	7
attacking, rejecting, ignoring, overdependent		unsupportive, inconsistent undermining		supportive but inconsistent		valued, supportive appreciative

8. What is the nature of the relationship between the victim and father?

___not applicable

1	2	3	4	5	6	7
attacking, rejecting, ignoring, overdependent		unsupportive, inconsistent undermining		supportive but inconsistent		valued, supportive appreciative

9. How would you rate the emotional "closeness" of the victim to the perpetrator? Please consider the length of time that the child knew the perpetrator and the extent to which the child had developed an emotional bond with the perpetrator.

1	2	3	4	5
no previous relationship (no closeness)		moderate closeness		relationship was one of most significant of child's associations (extreme closeness)

10a. How would you characterize the mother's response to disclosure?

___ not applicable

1	2	3	4	5	6	7
unsupportive to victim, rejecting angry, blaming victim, protective of offender; denying abuse		inconsistent support to victim; ambivalence towards victim; changes perspective; some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

10b. (If the father is not the offender) How would you characterize the father's response to disclosure. If the father is the offender, please check not applicable.

___not applicable

1	2	3	4	5	6	7
unsupportive to victim, rejecting angry, blaming victim, protective of offender; denying abuse		inconsistent support to victim; ambivalence towards victim; changes perspective; some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

11a. How would you characterize the level of supportiveness of the mother at this time?

___ not applicable

1	2	3	4	5	6	7
unsupportive to victim, rejecting angry, blaming victim, protective of offender; denying abuse		inconsistent support to victim; ambivalence towards victim; changes perspective some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

11b. (If the father is not the offender) How would you characterize the father's level of supportiveness at this time? If the father is the offender, please check not applicable.

___ not applicable

1	2	3	4	5	6	7
unsupportive to victim, rejecting angry, blaming victim, protective of offender; denying abuse		inconsistent support to victim; ambivalence towards victim; changes perspective; some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

12. How would you characterize the general level of supportiveness/reaction of the siblings and other relatives living at home at this time?

___ not applicable

1	2	3	4	5	6	7
unsupportive to victim, rejecting angry, blaming victim, protective of offender denying abuse		inconsistent support to victim; ambivalence towards victim;changes perspective; some anger at offender		generally supportive; angry at offender; upset re abuse; sensitive to victim with some confusion		very clear and consistently supportive to victim; angry at offender; very sensitive concerning impact of abuse on victim

13. Listed below are some other possible sources of support. Please identify them as indicated. For example, if the mother is supportive, check "yes", if she is not supportive check "no" and if there is no mother in the home check "not applicable". If there is a therapist involved and this is a source of support, check "yes' but if the therapist is not a source of support check "no" and if there is no therapist needed check "not applicable"

Source of support	Yes	No	Not applicable
mother	___	___	___
father	___	___	___
siblings	___	___	___
other relatives	___	___	___
friend	___	___	___
neighbours	___	___	___
co-workers	___	___	___
therapist/counsellor	___	___	___
social worker	___	___	___
other, specify ______________________	___	___	___

14. After disclosure, what level of emotional support did the family need?

___ not applicable

1 minimal support	2	3 medium support	4	5 high level of support

15. In your opinion, did the family receive the needed level of emotional support?
___yes
___no

16. Please indicate the family needs in general (check as many as apply)
___housing
___income
___child care
___counselling
___other, specify ______________________

17. What was the family support system before disclosure? (check as many as apply)
___friends
___immediate family
___co-workers
___other relatives
___others, specify ______________

18. What was the family support system after disclosure? (check as many as apply)

___friends
___immediate family
___co-workers
___other relatives
___others, specify ________________

19a. To what degree is the mother aware of (recognizes) the child's problems at this time? (e.g. behaviour, school, etc.)

1	2	3	4
not	slightly	very	completely
aware	aware	aware	aware

19b. To what degree is the father aware of (recognizes) the child's problems at this time? (e.g. behaviour, school, etc.)

1	2	3	4
not	slightly	very	completely
aware	aware	aware	aware

20a. In your opinion, how aware is the mother/caregiver of the child's needs at this time? (e.g. physical, emotional, mental/developmental)

1	2	3	4
not	slightly	very	completely
aware	aware	aware	aware

20b. In your opinion, how aware is the father of the child's needs at this time? (e.g. physical, emotional, mental/developmental)

1	2	3	4
not	slightly	very	completely
aware	aware	aware	aware

21a. In your opinion, to what degree is the mother capable of caring for the child in terms of:

A. Physical needs

1	2	3
incapable	moderately capable	very capable

B. Emotional needs

1	2	3
incapable	moderately capable	very capable

C. Mental/developmental needs

1	2	3
incapable	moderately capable	very capable

21b. In your opinion, to what degree is the father capable of caring for the child in terms of:

A. Physical needs

1	2	3
incapable	moderately capable	very capable

B. Emotional needs

1	2	3
incapable	moderately capable	very capable

C. Mental/developmental needs

1	2	3
incapable	moderately capable	very capable

22a. In your opinion, how reasonable are the expectations that the mother has for this child?

1	2	3
unreasonable	somewhat reasonable	very reasonable

22b. In your opinion, how reasonable are the expectations that the mother has for this child?

1	2	3
unreasonable	somewhat reasonable	very reasonable

23a. In your opinion, how capable is the mother of controlling her anger with this child?

1	2	3
incapable	moderately capable	very capable

23b. In your opinion, how capable is the father of controlling his anger with this child?

1	2	3
incapable	moderately capable	very capable

24. In your opinion, describe the ability of the family to protect the child from further abuse.

1	2	3	4	5	6	7
minimal ability to protect		some ability with lapses		generally good		excellent, no concerns

25. Please describe the level of cooperativeness of the non-offending spouse/parents to suggestions or directions from the Department.

1	2	3	4	5	6	7
highly resistive		somewhat resistive		somewhat cooperative		highly cooperative

26. The following is a list of services the family might require following disclosure. Please rate the family's level of need on the scale provided. If the family did not require a particular service, please check "not applicable"

a. **FINANCIAL** ___ not applicable	1 minimal	2	3 medium	4	5 high
b. **HOUSING** ___ not applicable	1 minimal	2	3 medium	4	5 high
c. **PARENTING SKILLS** __ not applicable	1 minimal	2	3 medium	4	5 high
d. **SUPPORT GROUP** ___ not applicable	1 minimal	2	3 medium	4	5 high
e. **INDIVIDUAL THERAPY** ___ not applicable	1 minimal	2	3 medium	4	5 high
f. **FAMILY THERAPY** ___ not applicable	1 minimal	2	3 medium	4	5 high

g. LEGAL SERVICES
___ not applicable

1	2	3	4	5
minimal		medium		high

h. EXTENDED FAMILY SUPPORT
___ not applicable

1	2	3	4	5
minimal		medium		high

27. We would like to ask you some questions about the child, the family and your relationships with them. Your frank responses to these questions will help us to understand the factors that contribute to the most effective response to cases of sexual abuse.

Each of the following questions asks you to provide a rating on a scale from 1-7. Several points on each scale are described. Please use your experience and judgment to circle the number that best describes each dimension.

a. ABOUT THE CHILD:

How emotionally disturbed or upset is the child by her/his sexual abuse experience at this time?

7	6	5	4	3	2	1
extremely			somewhat			not at all

How would you describe the impact the sexual abuse has had on the child's life? ___ negative impact ____ no impact ___ positive impact

Please rate the degree of impact the sexual abuse has had on the child's life.

1	2	3	4	5
a little		moderate		extreme

Generally speaking, how would you characterize her/his overall psychological adjustment?

7	6	5	4	3	2	1
very good			fair			very poor

Please check the 3 or 4 words listed below that best describe the child's feelings and experiences at this time.

___ accepted
___ ashamed
___ believed
___ blamed
___ cared for
___ confused
___ different
___ dirty
___ guilty
___ helpless
___ informed
___ isolated
___ mistrustful
___ liked
___ protected
___ rejected
___ safe
___ scared
___ strong
___ supported
___ trusting
___ understood

b. **ABOUT YOUR RELATIONSHIP:**

How would you characterize your relationship with the child at this time?

7	6	5	4	3	2	1
excellent		good		fair		poor

How would you characterize your feelings about the child at this time?

7	6	5	4	3	2	1
very positive		somewhat positive		somewhat negative		very negative

How comfortable are you with the child? (How much can you be yourself?)

7	6	5	4	3	2	1
very comfortable		somewhat comfortable		somewhat uncomfortable		very uncomfortable

How well do you feel you understand the child's needs and problems at this time?

7	6	5	4	3	2	1
extremely well			moderately			not at all

How much do you think the child trusts you at this time?

7	6	5	4	3	2	1
very much			moderately			not at all

c. **ABOUT YOUR RELATIONSHIP WITH THE FAMILY:**

How would you characterize your relationship with the mother/caregiver?

___ not applicable

7	6	5	4	3	2	1
excellent		good		fair		poor

(If the father is not the offender) How would you characterize your relationship with the father?

___ not applicable

7	6	5	4	3	2	1
excellent		good		fair		poor

How much do you think the mothercaregiver trusts you at this time?

___ not applicable

7	6	5	4	3	2	1
very much			moderately			not at all

(If the father is not the offender) How much do you think the father trusts you at this time?

7	6	5	4	3	2	1
very much			moderately			not at all

If there are any additional comments you would like to make about this child, the family or your relationships with them, please add them below.

___

___

___

28. One might conceptualize sexual abuse as ranging in seriousness along a continuum from less serious to very serious. From your experience with sexually abused children, please rate the seriousness of the effects of the sexual abuse on this child , using the following scale.

A rating of 1 indicates that the present case is similar to other cases of sexual abuse that you would consider to be less serious. A rating of 3 should indicate the present case is similar to the average case of sexual abuse for which you come in contact. A rating of 5 should indicate that the sexual abuse was extremely serious, much more serious than your average case.

1	2	3	4	5
least serious		moderately serious		extremely serious

29. One might conceptualize physical abuse as ranging in seriousness along a continuum from less serious to very serious. From your experience with physically abused children, please rate the seriousness of the effects of the physical abuse on this child , using the following scale.

A rating of 1 indicates that the present case is similar to other cases of physical abuse that you would consider to be less serious. A rating of 3 should indicate the present case is similar to the average case of physical abuse for which you come in contact. A rating of 5 should indicate that the physical abuse was extremely serious, much more serious than your average case. If physical abuse is not a factor, please check "not applicable"

___not applicable

1	2	3	4	5
least serious		moderately serious		extremely serious

30. Neglect may be conceptualized as failure to keep a child clean, fed, dressed, supervised and/or protected. It could also be failure to provide love, stimulation and/or attention. Neglect could range in seriousness along a continuum from less serious to very serious. From your experience with neglected children, please rate the seriousness of the effects of the neglect on this child, using the following scale.

A rating of 1 indicates that the present case is similar to other cases of neglect that you would consider to be less serious. A rating of 3 should indicate the present case is similar to the average case of neglect for which you come in contact. A rating of 5 should indicate that the neglect was extremely serious, much more serious than your average case. If neglect is not a factor, please check "not applicable"

___ not applicable

1	2	3	4	5
least serious		moderately serious		extremely serious

31. What decisions were made regarding intervention? (Check as many as apply).

___victim alone removed from home
___victim and mother removed from home
___victim sent to foster/group home
___victim sent to temporary care with other relatives
___offender removed from home
___victim referred for therapy
___offender referred for therapy
___family referred for therapy
___family referred for financial assistance
___case to be sent to criminal court
___other, specify ______________________________

32. **LEVEL OF VERIFICATION OF CASE AFTER INTAKE**

___ child sexual abuse does not appear to exist
___ child sexual abuse does not appear to exist, but requests or agrees to service
___ some grounds, but not sufficient evidence for (a) custody
(b) charges
___ some grounds but other factors warrant removal of the child from the home
___ verification of abuse, child stays with parent (s)
___ verification of abuse, child removed from parent(s)
___ verification of abuse, perpetrator removed from home
___ other, specify ____

33. COMPLAINT EVIDENCE

When a complaint is received, evidence is then collected during the investigation. This evidence (complaint evidence) may support or not support the complaint. Below is a list of different types of evidence. Using your judgement, please check the appropriate column.

Complaint evidence	support complaint	did not support complaint	don't know
a. child's statement	___	___	___
b. child's behaviour	___	___	___
c. family statements	___	___	___
d. family behaviour	___	___	___
e. medical investigation	___	___	___
f. police investigation	___	___	___
g. siblings or peers statements	___	___	___
h. collaborative witnesses statements	___	___	___

34. Was coercion used to gain the child's compliance with the sexual abuse?

___yes
___no

If yes, please indicate the type of coercion used.

___ status differential (implication that the child should do what an older person tells her to do)
___ use of blackmail to gain compliance ("if you don't, I'll tell what you did")
___ offer of reward, affection, privilege in exchange for compliance
___ threat of physical punishment if not compliant
___ implicit threat that affection, privilege or other positives will be taken away
___ use of physical punishment
___ threat of death
___ threat to family pets
___ other, specify ______________________________

35. Who were the workers and supervisor involved in the case?

intake worker number ____________________
Intake worker number ____________________
supervisor worker number ____________________
other worker numbers _______ ________ __________

36. **CASE TIME ESTIMATE:**

From the time of receiving the complaint or suspicion to the point of termination, try to accurately estimate the number of working hours this case required. NOTE: Estimates should include interviews, phone calls, making arrangements, case conferences, case note writing, school and parent contacts, foster parent contacts, etc.) FOR ALL WORKERS INVOLVED IN THIS CASE.

Circle the most accurate estimate.

1	2	3	4	5	6
less than 10 hours	11-30 hours	31-50 hours	51-70 hours	71-90 hours	91 or more hours

37. Please rate the following family dimensions from your knowledge of the family. Refer to the Level of Family Functioning Scale which follows.

a. relationship to environment ☐

b. cohesion ☐

c. emotional involvement ☐

d. marital relationships ☐

e. parent-child relationships ☐

f. sibling relationships ☐

g. decision making ☐

h. family stability ☐

i. organizational adaptability ☐

Data Schedule

ID number ______________

Complainant:

___mother
___father
___sibling
___grandparent
___other relative,specify
____

___friend
___neighbour
___teacher/principal/ guidance counsellor
___acquaintance
___other,specify
____

Date of complaint: ______year ______month ______day

1. FAMILY:

At time of offense, what was the type of family:

___ nuclear
___ stepfamily
___ one parent, one partner
___ one parent, several partners
___ common law
___ extended
___ foster/group home
___ other, ___________________

Was there evidence of marital conflict?

____ yes
____ no
____ don't know

Marital relationship:

___ stable (quality of marital relationship)
___ unstable

History of spouse abuse in present family?

___Yes
___No

History of child abuse in present family?

___Yes
___No

Socioeconomic factors Father:___ employed, full time
(check up to 2 major ones)
___ employed, part time
___ unemployed
___ welfare
___ UIC
___ disability pension
___ other, _______________

Mother: ___ employed, full time
(check up to 2 major ones)
___ employed, part time
___ unemployed
___ welfare
___ UIC
___ disability pension
___ other, ______________________

Is there any evidence of alcohol/drug problems with Mother ___Yes
___No
with Father ___Yes
___No

Previous problems: victim ___yes
___no

If yes, which of the following?

Victim:
___ behaviour
___ physical
___ emotional
___ academic
___ other, ________________
___ other, ________________

family ___yes
___no

If yes, which of the following?

Family:
___ alcohol/drug abuse
___ marital conflict
___ employment instability
___ history of child abuse
___ history of spouse abuse
___ emotional/psychological problems
___ psychological illness
___financial problems
___ child/parent problems
___social isolation
___ other, __________
___other, ___________

2. VICTIM:

Sex __ Male
__ Female

Other victims ___Yes
___No

Relationship to victim:
___sibling
___peer
___relative
___no relation

Age ______

Number of other victims, males ___
Number of other victims,females ___

ID number (s) of other victims ___
___
___

Home community of victim: ______________________________

Age at 1st abuse incident _______

Date abuse began: yr. ____ mo. ____ day ____ Date abuse ended:yr.___ mo.___ day ___

Community where the abuse took place:___________________________

Type of place where abuse took place:

- ___home of the victim
- ___home of the offender
- ___on the street
- ___neighbourhood of the victim
- ___in a car
- ___public place outdoors, i.e. playground, beach, park
- ___public place indoors, i.e. school, church, library
- ___don't know

Is there more than one incident ?___yes ___no.

If yes, approximate number of incidents. ____

Nature of abuse:
(code only 2 of these. For the major one, code 1; the other code 2)

- ___anal/vaginal intercourse
- ___oral - genital contact
- ___fondling
- ___exposure
- ___masturbation
- ___sexual harassment

Was there violence/coercion involved in the act?
___Yes
___No
___Don't know

Type of violence/coercion:
___verbal threat
___physical threat
___physical force
___physical force with injury
___rape
___psychological manipulation

Was the child in care when sexually abused? ___yes ___no
If yes, what type of care?
___foster home
___group home
___another relative
___ other, specify ____________________

COMPLAINT DISCLOSURE PATH:

A sexual abuse complaint can travel a number of different paths before it comes to the attention of Child and Family Services. Disclosure may occur at any point in the path of a complaint. Sometimes two parties are present at disclosure. With the following diagram and example, chart the path of the complaint and identify the point of disclosure.

example A: simple case

D
1. CFS <------- mother <------- victim

D
2. CFS <------- victim

D
3. CFS <------- RCMP <-------mother

<------- victim

example B: complex case

1. CFS <------- RCMP <------- mother

<------- RCMP
D victim

2. RCMP <------- CFS <------- mother
CFS
D victim

Complaint path:

A. _______ <----------- _______ <----------- _______ <----------- _______

_______ -----------> _______ -----------> _______ -----------> _______

_______ <----------- _______ <----------- _______ <----------- _______

_______ ----------> _______ ----------> _______ ----------> _______

B. Circle point of disclosure with **D.**

Date: Yr. ___ Mo. ___ Day ___

Is there evidence of family supportive at disclosure?

___Yes
___No
___Don't know

3. OFFENDER: If there is more than one offender, please fill out the following for the primary offender and fill out the last two pages for the secondary offender.

Offender Sex ___ Male
___ Female
Age _______

Home community of offender: ________________________________

Relationship to victim:

Family:

___ biological parent
___ step-parent
___ sibling
___ step-sibling
___ grandparent
___ aunt
___ uncle
___ cousin
___ in-law
___ foster parent
___ live in partner
___ other family member, specify,

____

Non-family:

___ friend
___ neighbour
___ acquaintance
___ babysitter
___ parent's boy/girlfriend
___ person in position of trust, specify

____
___ stranger

Was the offender previously investigated for sex offenses?

___Yes
___ No
___ Don't know

If yes, were charges laid?

___Yes
___No
___Don't know

If yes, was there a conviction?

___Yes
___No
___Don't know

Previous treatment for sex offenses

___ Yes
___ No
___ Don't know

Offender has a history of:
(code major problems 1,2)

___ alcohol abuse
___ drug abuse
___ emotional/psychological problems
___ family/marital problems
___ employment problems
___ victim of sexual abuse
___ victim of physical abuse
___ violent behaviour
___ problems with the law
___ sexual problems

Was offender under the influence of drugs/alcohol at the time of the abuse?

___Yes
___No
___Don't know

4. INVESTIGATION:

Date the CFS investigation began: __________

Date the police were notified: ____________

If there was a police investigation, in what jurisdiction did it take place?

___Alberton RCMP
___Borden Police
___Borden RCMP
___Charlottetown City Police
___Charlottetown RCMP
___Montague RCMP
___St. Eleanor's Police
___Summerside RCMP
___Summerside Town Police
___Sherwood/Parkdale RCMP
___Souris RCMP

Were criminal charges laid?

___Yes
___No
___Don't know

If yes, was there a conviction?

___Yes
___No
___Don't know

If yes, was there probation?

___Yes
___No
___Don't know

Was there a physical examination of the victim?

___Yes
___No
___Don't know

If yes, was there preparation for the physical exam?

___Yes
___No
___Don't know

Did the victim initially confirm or deny the accusations against the offender?

___confirm ___deny ___don't know

If denied, how long? ________ days

5. CASE CONTACTS* AND REFERRALS** FOR SERVICE:

* Contacts may be for providing or getting information about the victim or family.
** Referrals are for services to be provided.

Agency	Agency Contacted	Date of first contact	Referrals	Date
Community Mental Health	victim ___yes ___no	_______	victim ___yes ___no	______
	family ___yes ___no	_______	family ___yes ___no	______
Catholic Family Services	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______
Protestant Family Services	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______
Prince County Family	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______
Doctor	victim ___yes ___no	______	victim ___yes ___no	_____
	family ___yes ___no	______	family ___yes ___no	______
Psychiatrist	victim ___yes ___no	______	victim ___yes ___no	_____
	family ___yes ___no	______	family ___yes ___no	______

Psychologist in private practice/ agency	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______
Addiction Services	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______
School/guidance	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______
Hospital (QEH, Prince County, King's County, etc)	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______

Other agencies:

________________	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______
________________	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______
________________	victim ___yes ___no	______	victim ___yes ___no	______
	family ___yes ___no	______	family ___yes ___no	______

Legal Contacts:	**Contacted:**	
Prosecutor	___yes	___no
Probation	___yes	___no
Police	___yes	___no
Public defender	___yes	___no
Family court	___yes	___no
________________	___yes	___no
________________	___yes	___no
________________	___yes	___no
________________	___yes	___no

6. INTERVENTION:

	Date began	Date ended:
victim alone removed from home ___Yes ___No	________	________
victim & mother removed from home ___Yes ___No	________	________
victim & mother left home voluntarily ___Yes ___No	________	________
victim to foster/group home ___Yes ___No	________	________
offender removed from home ___No	________	________
case sent to court ___Yes ___No	________	________
victim testified in court ___Yes ___No	________	________
victim referred for therapy ___Yes ___No	________	________

6. INTERVENTION, continued — **Date began** — **Date ended**

family referred for therapy ________ ________
___Yes
___No

family referred to Social Services for additional services ________ ________
___Yes
___No

offender referred for therapy ________ ________
___Yes
___No

MISCELLANEOUS INFORMATION

Victim's social ties outside of the family? Please circle the appropriate number.

low		moderate		high
1	2	3	4	5

Parents' social ties outside of the family? Please circle the appropriate number.

low		moderate		high
1	2	3	4	5

FAMILY CHARACTERISTICS:

Cohesion - the degree to which family members feel committed to and help or support each other.
Expressiveness - openness of expression and sharing of feelings
Conflict - degree of anger, violence and struggle that characterize the family.

	low 1	moderate 2	high 3
cohesion |__|	extreme isolation of members or gross overinvolvement	minimal over/ under involvement	family close but some appropriate separateness

expressive-ness	☐	feelings concealed, overwhelming or absent	adequate expression of feelings with some difficulty	clear, open direct and sensitive
conflict	☐	warm, supportive, members get along well	a little anger, some blaming, some harmony	open anger, blaming discord, hostility, family members at war

While the child was in care, was there further abuse? ___Yes
___No

If yes, was it ___sexual abuse
___physical abuse

Was there a case plan? ___Yes If yes, how many? __________
___No

Date closed: Year____ Month ____ Day ____

Current disposition:

____

____

____

Outcome of the case:____

____

____

3. OFFENDER: Please fill this out if there is a second offender.

Offender Sex ___ Male
___ Female
Age ________

Home community of offender: ______________________________

Relationship to victim:

Family:

___ biological parent
___ step-parent
___ sibling
___ step-sibling
___ grandparent
___ aunt
___ uncle
___ cousin
___ in-law
___ foster parent
___ live in partner
___ other family member, specify,
____

Non-family:

___ friend
___ neighbour
___ acquaintance
___ babysitter
___ parent's boy/girlfriend
___ person in position of trust, specify
____
___ stranger

Was the offender previously investigated for sex offenses?
___Yes
___ No
___ Don't know

If yes, were charges laid?
___Yes
___No
___Don't know

If yes, was there a conviction?
___Yes
___No
___Don't know

Previous treatment for sex offenses
___ Yes
___ No
___ Don't know

Offender has a history of:
(code major problems 1,2)

___ alcohol abuse
___ drug abuse
___ emotional/psychological problems
___ family/marital problems
___ employment problems
___ victim of sexual abuse
___ victim of physical abuse
___ violent behaviour
___ problems with the law
___ sexual problems

Was offender under the influence of drugs/alcohol at the time of the abuse?
___Yes
___No
___Don't know

3. OFFENDER: Please fill this out if there is a third offender.

Offender Sex ___ Male
___ Female
Age _______

Home community of offender: ___________________________________

Relationship to victim:

Family:	Non-family:
___ biological parent	___ friend
___ step-parent	___ neighbour
___ sibling	___ acquaintance
___ step-sibling	___ babysitter
___ grandparent	___ parent's boy/ girlfriend
___ aunt	___ person in position of trust, specify ______________
___ uncle	___ stranger
___ cousin	
___ in-law	
___ foster parent	
___ live in partner	
___ other family member, specify, ____________________	

Was the offender previously investigated for sex offenses?

___Yes
___ No
___ Don't know

If yes, were charges laid?

___Yes
___No
___Don't know

If yes, was there a conviction?

___Yes
___No
___Don't know

Previous treatment for sex offenses

___ Yes
___ No
___ Don't know

Offender has a history of:
(code major problems 1,2)

___ alcohol abuse
___ drug abuse
___ emotional/psychological problems
___ family/marital problems
___ employment problems
___ victim of sexual abuse
___ victim of physical abuse
___ violent behaviour
___ problems with the law
___ sexual problems

Was offender under the influence of drugs/alcohol at the time of the abuse?

___Yes
___No
___Don't know

CASE PROBLEMS

ID NUMBER ____________

The following pages include a list of difficulties that a caseworker or a victim may encounter during a child sexual abuse case. The main purpose of this inventory is to identify the kinds of problems you or the victim experienced and where they originated.

The lists have been separated into areas which are listed below. Second, each list is far from complete. It would be very helpful if you identified specific problems that you experienced in this case and recorded them in the spaces provided. Any explanatory comments about these problems would be greatly appreciated.

You may wish to complete the different areas of problems as phases of the investigation and intervention are completed for either the victim and/or the family.

At the end of the instrument, there is a summary scale about the overall size of these problem areas.

PROBLEM AREAS

A. The Victim p. 1
B. The Family p. 1
C. The Offender p. 2
D. The Police p. 2
E. Crown Prosecutor p. 3
F. Victim Services p. 3
G. Court p. 4
Social Services and Victim p. 4
Social Services and Family p. 5
Therapy and Victim p. 5
Therapy and Family p. 5
Medical/Hospital p. 6
School p. 6

CASE PROBLEMS INDEX:

The difficulties and problems with each sexual abuse case can vary. Any number of these difficulties can have a negative impact on the case outcome. Below are a list of problem areas and difficulties within each area.

For this case, review each area of problems and determine whether it has been a problem (Yes, No). If it was a problem (Yes), then try to estimate how much of a problem it was in this particular case. Rate it as a small, moderate or large "problem".

NOTE: At the end of each category, please note the overall difficulties you experienced with aspects of this category of problems.

Did you have problems with:

If this was a problem, rate how much of a problem:

A. The Victim, specifically with:	**Yes**	**No**		**small**	**moderate**	**large**
1. age-related difficulties (child is very young, language, interviewing)			1.			
2. their cooperation with the investigation			2.			
3. their cooperation with the case plan			3.			
4. their cooperation with therapy			4.			
5. fears of being identified or labelled			5.			
6. insufficient support, other than family			6.			
7. other difficulties, please specify			7.			
8. other difficulties, please specify			8.			
	OVERALL					
B. The Family or non-offending parent	**Yes**	**No**		**small**	**moderate**	**large**
1. obtaining access to child or children			1.			
2.. lack of cooperation with the investigation			2.			
3. lack of cooperation with the case plan for victim or family			3			
4. lack of cooperation with the child's therapy			4.			
5. was this a multi-problem family			5.			
6. difficulties with validation			6.			
7. Insufficient family support for victims			7.			
8. other problems, specify			8.			
9. other problems, specify			9.			
	OVERALL					

Did you have a problem with:

If this was a problem, rate how much of a problem:

C. The Offender	Yes	No		small	moderate	large
1. interference with a. victim b. family c. witnesses			1.			
2. access to therapy services			2.			
3. complying with recognizance orders			3.			
4. other, specify			4.			
	OVERALL					

D. The Police	Yes	No		small	moderate	large
1. following protocols			1.			
2. prior consultation before investigation			2.			
3. cooperation during the investigation			3.			
4. interviewing or interaction skills during the investigation			4.			
5. lack of experience			5.			
6. understanding of their role			6.			
7. sensitivity to victim's situation			7.			
8. sensitivity to family's situation			8.			
9. length of time of investigation			9.			
10. length of time between completion of investigation and laying of charges			10.			
11. uncertainty of types of charges			11.			
12. turnover of investigators			12.			
13. willingness to obtain child's evidence			13.			
14. notification of witnesses			14.			
15. other, please specify			15.			
16. other, specify			16			
	OVERALL					

Did you have a problem with:

If this was a problem, rate how much of a problem:

E. Justice - Crown Prosecutor	Yes	No		small	moderate	large
1. role clarity or understanding (e.g. witness preparation			1.			
2. access to Crown (e.g. part-time prosecutor)			2.			
3. notification of witnesses including child			3.			
4. understanding of child sexual abuse dynamics			4.			
5. lack of Crown case awareness and preparation			5.			
6. sensitivity to victim and family			6.			
7. willingness to use child's evidence			7.			
8. insufficient flow of case information and judicial process			8.			
9. use of professional and expert witnesses			9.			
10. other, please specify			10.			
11. other, please specify			11.			
	OVERALL					

F. Justice - Victim Services	Yes	No		small	moderate	large
1. cooperation with Social Services				1		
2. coordination with Social Services (ongoing involvement, planning, etc)				2.		
3. coordination with the victim				3		
4. getting or receiving information from Victim Services				4.		
5. role clarification (e.g. witness preparation)				5.		
6. approach or introduction to victim and family				6.		
7. skills or training in dealing with the child and family				7.		
8. other, specify				8.		
9. other, specify				9.		
	OVERALL					

Did you have a problem with:

If this was a problem, rate how much of a problem:

G. Justice - Court	Yes	No		small	moderate	large
1. length of time before court			1.			
2. length of time from charges to plea			2.			
3. length of time from plea to hearing			3.			
4. length of time from hearing to final disposition (sentence)			4.			
5. scheduling of child's testimony			5.			
6. probation/parole - insufficient communication or information sharing			6.			
7. judicial sensitivity to victim and family			7.			
8. others, please specify			8.			
9. other, please specify			9.			
	OVERALL					
H. Social Services and victims	Yes	No		small	moderate	large
1. services not available for victim within region			1.			
2. availability of internal services for victim (e.g. foster homes)			2.			
3. turnover of workers on case			3.			
4. insufficient psychological or social information about victim for case plan			4.			
5. insufficient worker time available for intervention			5.			
6. other, specify			6.			
7. other, specify			7.			
	OVERALL					

Did you have a problem with:

If this was a problem, rate how much of a problem:

I. Social Services and Family	Yes	No		small	moderate	large
1. eligibility for service			1.			
2. accessibility to services/services available but delays			2.			
3. internal services not locally available			3.			
4. insufficient worker time available for intervention			4.			
5. other, specify			5.			
	OVERALL					

J. Therapy for victim	Yes	No		small	moderate	large
1. accessibility or long waiting list			1.			
2. therapeutic services not available locally			2.			
3. cooperation of referral agency			3.			
4. insufficient information about the nature of the services			4.			
5. confidentiality with therapist			5.			
6. information sharing with Social Services			6.			
7. quality of service			7.			
8. other, please specify			8			
9. other, please specify			9.			
	OVERALL					

K. Therapy for family	Yes	No		small	moderate	large
1. accessibility or long waiting list			1.			
2. therapeutic services not available locally			2.			
3. cooperation with agency			3.			
4. insufficient information about the nature of the services			4.			
5. confidentiality with therapist			5.			
6. information sharing			6.			
7. quality of service			7.			
8. time delays with service			8.			
9. service availability for siblings			9.			
10. other, please specify			10.			
	OVERALL					

Did you have a problem with:

If this was a problem, rate how much of a problem:

L. Medical/Hospital Personnel	Yes	No		small	moderate	large
1. scheduling examinations or office visits			1.			
2. level of hospital/medical sensitivity to victim and family			2.			
3. length of hospital waiting period			3.			
4. nature of hospital waiting facilities			4.			
5. availability of "willing" medical personnel			5.			
6. availability of medical personnel with sufficient expertise in examining children			6.			
7. level of knowledge of medical evidence requirements			7.			
8. other, specify			8.			
9. other, specify			9.			
		OVERALL				
M. School (if involved)	Yes	No		small	moderate	large
1. cooperation with investigation			1.			
2. confidentiality-too little, too much			2.			
3. overinvolvement with case			3.			
4. access to child			4.			
5. role clarity/understanding of roles			5.			
6. adequate interview facilities			6.			
7. under involvement with the case			7.			
8. difficulties with protocols			8.			
9. other, please specify			9.			
10. other, please specify			10.			

Difficulties or problems can affect the victim directly or indirectly through problems that a case worker may experience.

A. From the following list of problem areas, choose the three which you feel had the greatest negative impact on the victim.

Problem areas

A. The victim
B. The family
C. The offender
D. The police
E. Crown Prosecutor
F. Victim Services
G. Court
H. Social Services and victim
I. Social Services and family
J. Therapy and victim
K. Therapy and family
L. Medical/Hospital
M. School

1. Choose three for the victim:
Number 1. (specify area) ____________________
Number 2. (specify area) ____________________
Number 3. (specify area) ____________________

2. Rank them from largest to smallest problem area:
Rank 1. (specify area) ______________________
Rank 2. (specify area) ______________________
Rank 3. (specify area) ______________________

B. From the above list, choose those three areas that gave you the greatest difficulty in handling this case.

1. Choose the four major problem areas for you in the handling of this case:
Number 1. (specify area) ____________________
Number 2. (specify area) ____________________
Number 3. (specify area) ____________________
Number 4. (specify area) ____________________

2. Rank them from largest to smallest problem area with this case:
Rank 1. (specify area) ______________________
Rank 2. (specify area) ______________________
Rank 3. (specify area) ______________________
Rank 4 (specify area) ______________________

Option 1:

C. The four areas that you have just selected in section B should account for almost all of your problems with this case. Next, we would like you to estimate as accurately as possible how much each area accounted for or contributed to your overall difficulties with this case.

Consider the following example:

After reviewing a case, a worker felt that there were four major problem areas with this case - Crown Prosecutor, the offender, the family and the victim. Next, they estimated what percentage of their overall difficulties each area contributed to the total case problems.

The worker felt that at least half their problems came from the Crown Prosecutor. They estimated out, recorded below, Crown Prosecutor 50%. The offender was a major problem but not as much as the Crown Prosecutor. They estimated out, recorded below, offender 30%. Both the family and to some extent the victim were problematic but they were only minor sources of problems. They estimated that they were near equal. So the worker recorded below, family 10%, victim 10%.

Area 1, specify	Crown Prosecutor	50%
Area 2, specify	Offender	30%
Area 3, specify	Family	10%
Area 4, specify	Victim	10%
	total	100%

After reviewing the current case, try to estimate what percentage of your overall problems with this case came from or can be attributed to the areas that you identified in Section B.

NOTE: Your percentages should total to 100%.

Area 1 (specify) ______________________ ________%
Area 2 (specify) ______________________ ________%
Area 3 (specify) ______________________ ________%
Area 4 (specify) ______________________ ________%

Option 2:

C. Each area can contribute more to the overall problems with a case than others. You have just ranked the areas as sources of problems. Now, we would like to determine how much each area was a problem.

Using a total of 100 points, how would you weight these four areas (listed in Question 2) as sources of problems?

Consider this example:
In one case, a worker may weight problems as follows:

		No. of points
Rank 1, specific area	Crown Prosecutor	50
Rank 2, specific area	Family	30
Rank 3, specific area	Offender	10
Rank 4, specific area	Victim	10
	total	100 points

In the preceding example, the worker felt that nearly half her problems originated with the Crown Prosecutor (50 points). Second, the family was a fairly major problem (30 points) and the offender and victim were a source of problems but very minor and equal (10 points and 10 points).

No. of points

Rank 1, specify area ____________________ ________
Rank 2, specify area ____________________ ________
Rank 3, specify area ____________________ ________
Rank 4, specify area ____________________ ________

total 100 points

Survey of School Counsellors
Child Sexual Abuse Needs Assessment

As an important part of our needs assessment, we are interested in what happens in schools in regards to child sexual abuse. Because of the everyday involvement of schools in the lives of children, they play a central role in the processes of disclosure and prevention. We are interested in learning about what happens in schools in these two areas, and believe that counsellors are well situated to help inform us about them. Given the substantial problems with children's disclosure of sexual abuse to adults, it is very important for us to learn how children use people in the schools as "disclosure pathways", what happens once disclosures occur, and schools' experiences with reporting to agencies. We are also interested in your perception about the "atmosphere" in schools that children who might wish to disclose encounter, as well as programming in education and prevention. Your help in completing this survey will give us a good picture of what is happening in Island schools in regard to this problem, and help us to make meaningful suggestions for changes to make things better for children. Thank you.

Please answer these questions for the school that you work in. If you work in more than one school, please note any differences in practices and experiences that might occur in different schools. If you work in a regional office, please answer based on your knowledge for schools in your region.

1. Background. Date: Sex:___ female
___ male

Work setting: ___primary ___junior high ___high school
Do you work ___in the schools ___in a regional office

Do you work in ___rural schools ___urban schools ___both

In which school unit __#1 __#2 __#3 __#4 __#5

2. Please describe the various training experiences you have had related to sexual abuse. For each experience, please indicate the focus of the training (or the areas covered), the type of format (course, workshop, conference), the source (who presented the training), and the length of the training.

For each experience, please also rate its value to your understanding of sexual abuse using the scale described below.

Please list all the experiences you have had. Use an additional sheet if necessary.

1	2	3	4	5	6	7
not at all valuable			moderately valuable			extremely valuable

Focus (area)	Format (e.g. course, workshop, conference)	Source	Length	Value (1-7)

Disclosure:

3. Over the past two years, approximately how many students have disclosed sexual abuse to you?

___none ___1-5 ___6-10 ___11-20___ 21-30 __ 31-40 __ 41+

4. Over the past two years approximately how many cases of sexual abuse have you been involved in where disclosures were initially made to other teachers or staff?

___none ___1-5 ___6-10 ___11-20 ___21-30 ___31-40 ___41+

5a. Are there clearly understood internal procedures your school about what to do when a disclosure occurs? ___Yes ___No

5b. If Yes, please describe how this procedure was developed.
If No, what factors influence how sexual abuse cases are dealt with in your school.

6. Please describe what happens in your school when a child discloses to you directly.

7. Please describe what happens in your school when a child discloses to another staff member in the school.

8. If you work outside of specific schools, please describe how you are usually involved in child sexual abuse cases.

9. Please describe any counselling and supportive work that you have done with children who have disclosed in your school.

10. Have you ever received referrals from therapists or social services requesting your therapeutic or supportive involvement with sexually abused children?
___never ___a few times ___occasionally ___frequently

11. Please identify any problems or provide any additional information about the disclosure process in your school that you would like to bring to our attention.

There are a number of factors that are important in the creation of an atmosphere conducive to disclosure of sexual abuse. Schools (and the individuals in schools) will vary in their recognition and acknowledgement of the sexual abuse problem, on whether there is a sense of approachability or openness to discussing a sexual abuse experience and in the sensitivity of response to a disclosure of sexual abuse. From all your experiences with the school system and the people with whom you've become familiar,please rate your general perceptions of (a) teachers, (b) administrators and (c) other counsellors on the factors discussed above.

12. For each group, rate their level of recognition and acknowledgement that sexual abuse is a serious problem.

		very poor	poor	fair	good	very good	excellent
(a)	teachers	1	2	3	4	5	6
(b)	administrators	1	2	3	4	5	6
(c)	other counsellors	1	2	3	4	5	6

13. For each group, rate their level of approachability and openness to disclosures of child sexual abuse.

		very poor	poor	fair	good	very good	excellent
(a)	teachers	1	2	3	4	5	6
(b)	administrators	1	2	3	4	5	6
(c)	other counsellors	1	2	3	4	5	6

14. For each group, rate their level of sensitivity of response to victims of child sexual abuse once a disclosure has occurred.

		very poor	poor	fair	good	very good	excellent
(a)	teachers	1	2	3	4	5	(
(b)	administrators	1	2	3	4	5	6
(c)	other counsellors	1	2	3	4	5	6

15. Please also rate your perceptions of these same groups on:

1. level of knowledge of behavioural/physical indicators of child sexual abuse:

		very poor	poor	fair	good	very good	excellent
(a)	teachers	1	2	3	4	5	6
(b)	administrators	1	2	3	4	5	6
(c)	other counsellors	1	2	3	4	5	6

2. dynamics of victims of child sexual abuse:

		very poor	poor	fair	good	very good	excellent
(a)	teachers	1	2	3	4	5	6
(b)	administrators	1	2	3	4	5	6
(c)	other counsellors	1	2	3	4	5	6

16. Rate the level of familiarity with legal requirements to report child sexual abuse under the Criminal Code for the following groups:

		1 very familiar	2 quite familiar	3 somewhat familiar	4 slightly familiar	5 not familiar
(a)	teachers	1	2	3	4	5
(b)	administrators	1	2	3	4	5
(c)	other counsellors	1	2	3	4	5

17. Rate the familiarity with school unit procedures and protocols for responding to disclosures of child sexual abuse for the following groups:

		1 very familiar	2 quite familiar	3 somewhat familiar	4 slightly familiar	5 not familiar
(a)	teachers	1	2	3	4	5
(b)	administrators	1	2	3	4	5
(c)	other counsellors	1	2	3	4	5

18. Generally speaking, how would you characterize the quality of the supportiveness in the atmosphere of your school for victims who might wish to disclose child sexual abuse?

1	2	3	4	5	6
very poor	poor	fair	good	very good	excellent

19. Generally speaking, when a student in your school does disclose sexual abuse, how public or private does knowledge about her/his situation become among staff and students? Check the most accurate description.

____ Very private (only those most directly involved with the disclosure will know)

____ Fairly private (very few other people will know)

____ Fairly public (many other people will know)

____ Very public (the majority of people will know)

Referral/reporting:

20. Who usually reports disclosures of child sexual abuse to Social Services or the police in your school?

21. To which agency is sexual abuse usually reported?
___Social Services ___police ___Both

22. In your opinion, which of the statements below best describes the frequency of reporting of sexual abuse cases to Social Services or police in your school?
    - __ All cases that staff members learn about are reported.
    - __ Almost all cases that staff members learn about are reported.
    - __ Most cases that staff members learn about are reported.
    - __ The majority of cases that staff members learn about are reported.
    - __ Some cases that staff members learn about are reported.
    - __ A few of the cases that staff members learn about are reported.
    - __ Almost none of the cases that staff members learn about are reported.

23a. When a case is reported to Social Services, how long does it usually take until the child is interviewed by a worker?

23b. If there are problems with delays, please describe.

24a. When a case is reported to the police, how long does it usually take until the child is interviewed by an officer?

24b. If there are problems with delays, please describe.

25. Please identify any problems you see with the disruptiveness or sensitivity of the Social Service's (or police) investigation-interviewing process in relation to the child's experience in school (e.g.where its conducted, how public is agency presence, taking children out of school, etc.).

a.

b.

c.

26. When you make a report to Social Services, how often do they communicate with you about what happens in that case?
__for almost all cases __for most cases __for the majority of cases
__for some cases __for very few cases

27. How satisfied are you with Social Services' communication with you about what happens with a child after they are referred?
___very satisfied ___somewhat satisfied ___somewhat dissatisfied
___very dissatisfied

28. Please comment on any communication problems with Social Services.

29. How frequently do you make referrals for therapy for those sexual abuse cases reported in your school?
___for almost all cases ___for most cases ___for the majority of cases
___for some cases ___for very few cases

30. To what agency and/or person(s) do you usually refer a child for therapy?

31a. How long does it usually take for them to be interviewed?

31b. If there are problems with delays, please describe.

32a. How satisfied are you with therapists' communication with you about what happens with a case after referral?
___very satisfied ___somewhat satisfied ___somewhat dissatisfied
___very dissatisfied

32b. Please comment on any problems with communication with therapists.

33. Please describe any problems you are aware of with the referral and reporting process.

34a. Do you think the schools could be more involved in the response to child sexual abuse? __Yes __No

34b. If yes,please describe how.

Prevention and Education:

35a. Is there a prevention/education programme for child sexual abuse in your school? ___Yes __No

35b. Please describe the programme, what children it is for, its frequency, length, etc.

35c. In your opinion, how valuable is this programme in educating children about sexual abuse?

not at all valuable			moderately valuable			extremely valuable
1	2	3	4	5	6	7

36a. Is there a sex education (or family life)programme in your school ? ___Yes___No

36b. If Yes, how valuable do you think this programme is in educating children in ways that help to address the child sexual abuse problem.

not at all valuable			moderately valuable			extremely valuable
1	2	3	4	5	6	7

36c. If No, how valuable do you think such a programme would be in educating children in ways that would help to address the sexual abuse problem?

not at all valuable			moderately valuable			extremely valuable
1	2	3	4	5	6	7

Conclusions/Suggestions:

37. Please offer any suggestions you have about how schools could respond more effectively to child sexual abuse for the following areas.

1. Disclosure/reporting
   a.

   b.

   c.

2. Prevention/education
   a.

   b.

   c.

38. What ideas do you have for making it easier for children to more readily disclose their experiences of sexual abuse to teachers and counsellors? (for example, school/programme changes, needed training experiences).

a.

b.

c.

39a. Should the schools be playing a different role, or a greater role in dealing with the sexual abuse problem?__Yes __No

39b. If yes, please describe how.

40. Please include any other comments you would like to make about your perspective on the sexual abuse problem.

Please enclose this questionnaire in the envelope provided and return it by May 20, 1991. Thank you very much for your help in giving us some needed information about the response to the sexual abuse problem in Island schools.

INTERVIEW GUIDE FOR FAMILIES

BACKGROUND DATA ON THE FAMILY

ID number ________________ Date ____year____month____day

A.	What was the relationship of the victim to the informant?	1=mother 2=father 3=sibling 4=grandparent 5=other relative, specify ______________________ 6=friend 7=neighbour 8=teacher/principal/ guidance counsellor 9=acquaintance 10=other, specify ______________________
B.	What is your current marital status?	1=single 2=common law, one partner 3=common law, several partners 4=divorced 5=separated 6=widowed 7=married

C.	What is the relationship of the perpetrator to the victim?	1=biological parent 2=step-parent 3=sibling 4=step-sibling 5=grandparent 6=aunt 7=uncle 8=cousin 9=in-law 10=foster parent 11=live in partner 12=other family member, ____________ 13=friend 14=neighbour 15=acquaintance 16=babysitter 17=parent's boy/girlfriend 18=person in position of trust, specify ________ ____________ 19=adopted parent 20=other, specify __________
D.	Where is the victim currently living?	1=at home, with parent (s) 2=with another relative 3=foster/group home 4=with friends 5=in own apartment/room 6=other, specify ____________
E.	Does the perpetrator live in the home?	1=yes 2=no

PREDISCLOSURE - FAMILIAL

Throughout this interview, I'll be asking you about your status, relationships, support and so forth at different times during the sexual abuse problem and subsequent process that you went through. Before each one I'll tell you what time I'm going to ask you to think about and then I'll ask questions relating to that time. I'd like you now to think about the time before disclosure occurred and the following questions will be about that time.

1.	What was your marital status?	1=single/divorced, no partner 2=single/divorced,one partner 3=single/divorced,several partners 4=married, biological parents 5=married, stepfamily 6=common law 7=separated 8=extended family 9=other,________________
2.	Were there marital problems?	1=yes 2=no
3.	What was the occupation of the parent(s)?	______________________

4a.	Were there family problems?	1=yes 2=no
4b.	If yes, identify.	1=alcohol/drug abuse 2=marital conflict 3=employment instability 4=history of child abuse 5=history of spouse abuse 6=emotional/psychological problems 7=psychological illness 8=financial problems 9=social isolation 10=child-parent problems 11=other, ________
5a.	Were there any major traumas the family had to deal with?	1=yes 2=no
5b.	If yes, identify.	1=death in the family 2=job loss 3=major illness 4=family breakup 5=other, ________________
6.	Did the family (mother) have good person or persons they could turn to for support outside of the family? (i.e. close contacts, not isolated from the community)	1=yes 2=no

For the following items, please indicate some key statements which would verify the rating scales.

7a. What was the level of support from the extended family to your family?

0	1	2	3	4	5	6	7-
no involvement	unsupportive to family; rejecting		inconsistent support to family; ambivalence towards family;changes perspective		generally supportive;		very clear and consistently supportive to family

Key statements that support the rating:

7b. What was the level of contact with the extended family?

1	2	3	4	5	6	7
none		occasionally		frequently		daily

Key statements that support the rating:

8. Describe the relationship between mother and victim in terms of:

a. support

0	1	2	3	4	5	6	7
no involvement	attacking; rejecting; ignoring; overdependent		unsupportive; inconsistent; undermining;		supportive generally		valued supportive; appreciative

Key statements that support the rating:____

____

____

b. closeness

0	1	2	3	4	5
no involvement	LOW extreme isolation or overinvolvement		MODERATE minimal over/ under involvement		HIGH close but appropriate separateness

Key statements that support the rating: ____________________

____

____

c. conflict

0	1	2	3	4	5
no involvement	LOW warm, supportive get along with each other		MODERATE a little anger, some blaming, some harmony		HIGH open anger, blaming, discord hostility, at war with each other

Key statements that support the rating: ____________________

____

____

9. Describe the relationship between the father and victim in terms of:

a. support

0	1	2	3	4	5	6	7
no involvement	attacking; rejecting; ignoring; overdependent		unsupportive; inconsistent; undermining;		supportive generally		valued supportive; appreciative

Key statements that support the rating: ____________________

b. closeness

0	1	2	3	4	5
no involvement	LOW extreme isolation or overinvolvement		MODERATE minimal over/ under involvement		HIGH close but appropriate separateness

Key statements that support the rating: ____________________

c. conflict

0	1	2	3	4	5
no involvement	LOW warm, supportive get along with each other		MODERATE a little anger, some blaming, some harmony		HIGH open anger, blaming, discord hostility, at war with each other

Key statements that support the rating: ____________________

10. Describe the relationship between the victim and siblings in terms of:

In extrafamilial cases, use "FAMILY" instead of "SIBLINGS".

a. support

0	1	2	3	4	5	6	7
no involvement	attacking; rejecting; ignoring; overdependent		unsupportive; inconsistent; undermining;		supportive generally		valued supportive; appreciative

Key statements that support the rating: ______________________________

____

____

b. closeness

0	1	2	3	4	5
no involvement	LOW extreme isolation or overinvolvement		MODERATE minimal over/ under involvement		HIGH close but appropriate separateness

Key statements that support the rating: ______________________________

____

____

0 c. conflict

0	1	2	3	4	5
no involvement	LOW warm, supportive get along with each other		MODERATE a little anger, some blaming, some harmony		HIGH open anger, blaming, discord hostility, at war

Key statements that support the rating: ____________________

____

____

11. Person to whom victim was closest during this period.

1=mother
2=father
3=sibling(s)
4=aunt/uncle
5=grandparent(s)
6=other relative, ________
____
7=friend(s)
8=teacher/guidance counsellor
9=therapist/counsellor
10=social worker
11=no one
12=other, ________

12a. Did the victim display any emotional problems?

1=yes
2=no

12b. If yes, identify ____________________

____

12c. Did the victim display any physical problems?

1=yes
2=no

12d. If yes, identify ____

____

12e. Did the victim display any behavioural problems?
1=yes
2=no

12f. If yes, identify ____

____

DISCLOSURE

Now I'm going to ask you to think about the time when your child disclosed the sexual abuse. The following questions will all deal with what was happening at the time of disclosure.

13. To whom did the victim disclose? Who was the first person told that led to the reporting?
1=mother
2=father
3=sibling
4=grandparent
5=other relative, specify
____
6=friend
7=neighbour
8=teacher/principal/guidance counsellor
9=therapist/counsellor
10=social worker
11=other, specify,
____

14. When the victim disclosed, how old was she/he? __________ years

15a. Did the victim ever disclose previously?
1=yes
2=no

15b. If yes, to whom?

1=mother
2=father
3=sibling
4=grandparent
5=other relative, specify
____
6=friend
7=neighbour
8=teacher/principal/guidance counsellor
9=therapist/counsellor
10=social worker
11=other, specify,
____

16a. Did the victim ever exhibit any signs that would have led you to suspect of sexual abuse previously?

1=yes
2=no

16b. If yes, what were the signs? ____
____

17. What factors led to disclosure?

1=observation by a third party
2=physical injury to the victim
3=pregnancy of the victim
4=acting out behaviour
5=precocious sexual activity initiated by victim
6=victim telling a third party
7=venereal disease in victim
8=other, _________________

18a. To whom wa[illegible]his case reported?

1=police
2=Social Services
3=other, _________________

18b. Who did the reporting? ____

19. If victim told a third party, what factors led to this?

1=to obtain protection for herself
2=to obtain protection for other children
3=relief of guilt or shame
4=desire for more freedom from offender
5=resentment/anger/hostility towards offender
6=reaching puberty
7=fear of pregnancy
8=information on T.V. or education about sexual abuse

9=other, ____________________

20. Who informed you of the disclosure?

1=sibling of the victim
2=victim's friend
3=teacher/guidance/principal
4=your friend
5=parent of victim's friend
6=relative, __________________
7=social worker
8=police
9=therapist/counsellor
10=clergy
11=babysitter
12=other, __________________

21a. What was your (mother) initial reaction?

1=shock/horror
2=anger/hostility toward victim
3=anger/hostility toward offender
4=guilt over previous failure to protect victim
5=denial of victimization
6=denial of impact on victim
7=anxiety over impact on victim
8=anxiety over disruption of family
9=anxiety over physical violence from offender
10=conflict of loyalties between victim and offender
11=self-interest/self-defence/self protection
12=withdrawal
13=disbelief of victim
14=blaming victim
15=protective toward victim
16=obtained outside assistance
17=cooperated with outside authorities
18=confusion

19=other,________________

21b. **In extrafamilial cases ask:**
What was the initial reaction of the father?

1=shock/horror
2=anger/hostility toward victim
3=anger/hostility toward offender
4=guilt over previous failure to protect victim
5=denial of victimization
6=denial of impact on victim
7=anxiety over impact on victim
8=anxiety over disruption of family
9=anxiety over physical violence from offender
10=conflict of loyalties between victim and offender
11=self-interest/self-defence/self protection
12=withdrawal
13=disbelief of victim
14=blaming victim
15=protective toward victim
16=obtained outside assistance
17=cooperated with outside authorities
18=confusion

19=other,________________

22. What was the initial reaction of the perpetrator?

1=denial of the abuse
2=anger at victim
3=anger at spouse
4=blaming the victim
5=guilt
6=shame
7=fear
8=acknowledging responsibility
9=cooperative with outside authorities
10=broke down
11=other,________________

23. What was the initial reaction of the siblings if they found out within 2 months?

1=shock/horror
2=anger/hostility toward victim
3=anger/hostility toward offender
4=guilt over previous failure to protect victim
5=denial of victimization
6=denial of impact on victim
7=anxiety over impact on victim
8=anxiety over disruption of family
9=anxiety over physical violence from offender
10=conflict of loyalties between victim and offender
11=self-interest/self-defence/self protection
12=withdrawal
13=disbelief of victim
14=blaming victim
15=protective toward victim
16=obtained outside assistance
17=cooperated with outside authorities
18=never found out

19=other, ______________

24a. What was the initial reaction of the extended family if they found out within 2 months?

1=shock/horror
2=anger/hostility toward victim
3=anger/hostility toward offender
4=guilt over previous failure to protect victim
5=denial of victimization
6=denial of impact on victim
7=anxiety over impact on victim
8=anxiety over disruption of family
9=anxiety over physical violence from offender
10=conflict of loyalties between victim and offender
11=self-interest/self-defence/self protection
12=withdrawal
13=disbelief of victim
14=blaming victim
15=protective toward victim
16=obtained outside assistance
17=cooperated with outside authorities
18=never found out
19=other, _______________

24b.	**In extrafamilial cases ask:** What was the reaction of significant others if they found out within 2 months?	1=shock/horror 2=anger/hostility toward victim 3=anger/hostility toward offender 4=guilt over previous failure to protect victim 5=denial of victimization 6=denial of impact on victim 7=anxiety over impact on victim 8=anxiety over disruption of family 9=anxiety over physical violence from offender 10=conflict of loyalties between victim and offender 11=self-interest/self-defence/self protection 12=withdrawal 13=disbelief of victim 14=blaming victim 15=protective toward victim 16=obtained outside assistance 17=cooperated with outside authorities 18=never found out 19=other, _______________
25.	Were there any problems identified concerning reporting?	1=disbelief of victim 2=did not know how to report 3=was slow in reporting 4=was afraid of getting involved 5=was afraid what offender might do 6=didn't know what to report 7=other, _______________

26a. What, if anything, could or should have been done to help the victim during this period? ______

26b. Please indicate what you think needs to happen so that victims will not be afraid to disclose sexual abuse. ______

27a. What needs to be done to assist victims in the process of reporting sexual abuse? ______

27b. What needs to be done to assist persons in reporting to agencies? ______

28a. Who was the most supportive person to you during the time of disclosure? ______

28b. Who was the most supportive person to the victim during the time of disclosure? ______

29. Please identify any of the following which may have occurred after disclosure?	1=investigation by police 2=investigation by Child and Family Services 3=medical examination 4=removal of the victim from the family 5=removal of the offender from the home 6=removal of victim and mother from home 7=mother and victim voluntarily left home 8=prosecution of offender 9=jailing of offender 10=therapy for victim 11=therapy for other family members 12=therapy for offender 13=other consequences, ________________

INVESTIGATION BY POLICE:

This area deals with questions that focus on the investigation process by the police - interviews, contacts.

The next questions are all going to be about the police investigation. If you would think about what was happening during that time, I'll ask you some questions about it.

30.	How soon after disclosure did the police investigate?	1=< 24 hours 2=48 hours 3=3-7 days 4=> one week
31.	How many times did the police interview the victim?	______________ times If respondent is uncertain, use the following categories: 1 time, 2-4 times 5-7 times 8 or more times
32a.	Did the police investigation cause emotional upset to the child?	1=yes 2=no
32b.	If yes, how upset?	

1	2	3	4	5	6	7
not upsetting		somewhat upsetting		moderately upsetting		strongly upsetting

33. Was it upsetting due to?

1=the questions the police asked the victim
2=where the police interviewed the victim
3=number of times the police interviewed the victim
4=negative attitude toward the victim
5=negative attitude toward the parents
6=negative attitude toward significant others
8=difficult for the victim to talk about the experience
9=fearful of the consequences
10=other,________________

34. Were you interviewed by police?

1=yes
2=no

35a. Did you have any problems or concerns about the police investigation?

1=yes
2=no

35b. If yes, please indicate, ________________________
____

36a. If you could recommend changes in how police investigated your child, what would you recommend?
____
____

36b. Who was the most supportive person to you during the time of the investigation by the police? ________________________

36c. Who was the most supportive person to the victim during the time of the investigation by the police? ________________________

INVESTIGATION BY CHILD AND FAMILY SERVICES:

Focus on the experience during the investigative interviews, i.e. information to substantiate the complaint or decisions to intervene. It does not include the intervention experiences, i.e. referral to therapy, etc.

Sometime after disclosure took place, there was an investigation by Child and Family Services. Thinking back to that investigation, I'd like you to answer the following questions.

37.	How soon after disclosure did Child and Family Services investigate?	1=<24 hours 2=48 hours 3=3-7 days 4=> one week
38.	How many time did CFS interview the victim?	______________times If the respondent is uncertain, use the following categories. 1 time 2-4 times 5-7 times 8 or more times.
39a.	Did the CFS investigation cause emotional upset to the child?	1=yes 2=no
39b.	If yes, how upset?	

1	2	3	4	5	6	7
not upsetting		somewhat upsetting		moderately upsetting		strongly upsetting

40. Was it upsetting due to?

1=the questions CFS asked the victim
2=where CFS interviewed the victim
3=number of times CFS interviewed the victim
4=negative attitude toward the victim
5=negative attitude toward the parents
6=negative attitude toward significant others
8=difficult for the victim to talk about the experience
9=how the questions were asked
10=other, ______________

41a. Please indicate anything which was helpful to the victim during the CFS investigation. ____

____

41b. Please indicate anything which was helpful to you during the CFS investigation.

____

____

42a. Please indicate things which were unhelpful to the victim during this period. ______________________________

____

43. Were you interviewed by Child and Family Services?

1=yes
2=no

44. If you were going to recommend changes in how Child and Family Services investigated your child and family, what would you recommend? ________________________________
____
____

45. Who was the most supportive to you during this time of investigation by CFS? ____________________________________

46. Who was the most supportive to the victim during this time of investigation by CFS? ______________________________________

OVERALL INVESTIGATION:

We've talked about the investigation by Child and Family Services and the investigation by the police as separate topics. Now I would like you to think about the investigation overall and to answer some questions about it.

47. Please rate the level of helpfulness of each of the following to the victim during the investigative period.

a. police

0	1	2	3	4	5
no involvement	extremely hindering		some help some hindering		extremely helpful

b. Child and Family Services

0	1	2	3	4	5
no involvement	extremely hindering		some help some hindering		extremely helpful

c. mother

0	1	2	3	4	5
no involvement	extremely hindering		some help some hindering		extremely helpful

d. siblings

0	1	2	3	4	5
no involvement	extremely hindering		some help some hindering		extremely helpful

e. other relatives

0	1	2	3	4	5
no involvement	extremely hindering		some help some hindering		extremely helpful

f. friends

0	1	2	3	4	5
no involvement	extremely hindering		some help some hindering		extremely helpful

g. others, ______________________________

0	1	2	3	4	5
no involvement	extremely hindering		some help some hindering		extremely helpful

48a. Did there appear to be any problems in cooperation and communication between the police and Child and Family Services?

1=yes
2=no

48b. If yes, please indicate the problems. ______________________
____

49. What, if anything, would have been helpful for you to be able to cope better during this investigative process? ______________________________
____

50. What, if anything, would have been helpful to the victim to be able to cope better during this investigative process? ______________________________
____

51. Who was the most supportive to you during the whole investigative process? ______________________________
____

52. Who was the most supportive to the victim during the whole investigative process? ________________________________

____

53. What things should be changed during the investigative process to make things better for the victim? ________________________________

____

INTERVENTION

This includes decisions made to intervene by Child and Family Services including housing, child protection, financial, foster care, etc.

Now I'd like to ask you some questions about services that you might have received and the people that gave these services to you.

54. Please indicate the services that you (family) required.

1=financial
2=shelter
3=child care
4=homemaker
5=emotional support
6=transportation
7=other, specify_ ____________________

55. Please indicate the services that the victim required.

1=financial
2=shelter
3=child care
4=homemaker
5=emotional support
6=other, specify_ ____________________

56. How would you describe the Child and Family Services worker's response to you based on:

a. friendly, likeable, sociable, warmth

1	2	3	4	5
low		medium		high

b. honest, reliable, sincere, trustworthy

1	2	3	4	5
low		medium		high

c. experienced, well prepared, competent, knowledgeable

1	2	3	4	5
low		medium		high

57. In your opinion, how did the CFS worker respond to the victim based on:

a. friendly, likeable, sociable, warmth

1	2	3	4	5
low		medium		high

b. honest, reliable, sincere, trustworthy

1	2	3	4	5
low		medium		high

c. experienced, well prepared, competent, knowledgeable

1	2	3	4	5
low		medium		high

58.	Did the CFS worker involve you in decision making?	1=yes 2=no
59.	Did the CFS worker involve the victim in decision making?	1=yes 2=no
60.	Did the CFS worker inform you about decisions?	1=yes 2=no
61.	Did the CFS worker inform the victim about decisions?	1=yes 2=no

62. Who were the most supportive people to the victim in order of priority?
1=____________
2=____________
3=____________

63. Who was the least supportive person to the victim? ________________

64. Who were the most supportive people to you in order of priority?
1=____________
2=____________
3=____________

65. Who was the least supportive person to you? ________________

66. Please identify the most helpful experiences to you during the intervention process by Child and Family Services.
____
____

67. Please identify the least supportive experiences you had during the CFS intervention process. __________________________________
____

68. In your opinion, what would have been most helpful in assisting you to cope better during this time? ______________________________
____

69. In your opinion, what would have been most helpful in assisting the victim to cope better during this time? ____________________________
____

70. If you could make any changes which could make things better for you during the intervention process by CFS, what would they be? _______

____

____

71. If you could make any changes which could make things better for the victim during the intervention process by CFS, what would they be?

____

____

____

INTERVENTION - COURT PROCESS

Now I'd like you to think about the court process and what steps you went through and how you were treated during the time of court. The following questions will all be about the court process.

72. Please identify the charges laid against the perpetrator.
____
____

73a. When were the charges laid? ____year____month____day

73b. After investigation in ___ 1 week ___1 month ___ 2 months

74a. When was your scheduled court appearance? ____year____month____day

74b. After charges laid ___1 week ___1 month ___2 months ___3 months

75. How long did it take to complete the court process? ___1 month ___2 months ___3 months ___ 6 months ___ongoing

76. Was the victim interviewed previous to going to court to testify?
1=yes
2=no

77. Who interviewed the victim? ____

78a. How many times was the victim interviewed? _____________times

78b. If respondent is uncertain, use these categories.
1=1 time
2=2-4 times
3=5-7 times
4=8 or more times

79. Please describe the level of support the victim received in going to court.

___ don't know

1	2	3
Low	Medium	High

80. Please describe the level of upset the victim may have experienced through each of the following processes:

a. police investigation for court

___ not applicable

1	2	3	4
not at all upset	somewhat upset	considerably upset	extremely upset

b. preparation by Crown Prosecutor

___ not applicable

1	2	3	4
not at all upset	somewhat upset	considerably upset	extremely upset

c. testifying in court

___ not applicable

1	2	3	4
not at all upset	somewhat upset	considerably upset	extremely upset

81. In the above categories of "extremely upset" and "considerably upset", please indicate the key factors that may have been the cause of the upset.

1=child not properly prepared
2=lack of emotional support
3=lack of sensitivity by Crown
4=lack of sensitivity by police
5=lack of sensitivity by judge
6=lack of awareness by judge
7=court process intimidating
8=child worried about what's going to happen
9=breakup of family
10=delays
11=other, specify ____________________

82. Who supplied the main support to you through this process?
____

83. Who supplied the main support to the victim through this process?
____

84. Please describe the nature of your relationship with the victim through this process.

85. What was the disposition of the case by the courts? ____________________
____

86a. How did the victim feel about the disposition of the case?

1=happy
2=ambivalent
3=unhappy
4=not sure

86b. If the victim was unhappy, why? ____________________

____

87a. How did you feel about the disposition of the case?

1=happy
2=ambivalent
3=unhappy
4=not sure

87b. If you were unhappy, why? ____________________

____

88. Please describe the most helpful events/experiences that assisted you in coping with the court process. ____________________

____

____

89. Please describe the most helpful events/experiences that assisted the victim in coping with the court process. ____________

____

____

90. What could have assisted you to cope better with the court process?

____

____

91. What could have assisted the victim to cope better with the court process?

____

____

92. If you could make changes in the Court process to improve it and to support the victim, what would those changes be? ____________________

____

____

THERAPY

The next series of questions all deal with therapy. This means therapy for the victim, you and your family as well as the perpetrator. Thinking back over the therapy process, I'd like you to answer the following questions.

93a.	Did the victim go for therapy?	1=yes 2=no
93b.	Was the victim referred for therapy?	1=yes 2=no

93c. If yes, who referred? ______________________________

94a.	If victim was not referred, did you have any problem with this?	1=yes 2=no

94b. Please indicate ______________________________

____

95a.	Did the victim go on her/his own for therapy?	1=yes 2=no
95b.	If no, why not?	1=therapy not available 2=too far away 3=not necessary 4=waiting time too long 5=decision by victim not to go 6=decision by family not to go 7=not aware of service 8=other, specify ______________
96a.	Did you go for therapy?	1=yes 2=no

96b.	Were you referred for therapy?	1=yes 2=no
96c.	If yes, who referred you? ____________________	
97a.	Did you go on your own for therapy?	1=yes 2=no
97b.	If no, why not?	1=therapy not available 2=too far away 3=not necessary 4=waiting time too long 5=decision by victim not to go 6=decision by family not to go 7=not aware of service 8=other, specify ____________
98a.	Did your family go for therapy?	1=yes 2=no
98b.	Was the family referred for therapy?	1=yes 2=no
98c.	If yes, who referred? ____________________	
99a.	Did the family go on their own for therapy?	1=yes 2=no
99b.	If no, why not?	1=therapy not available 2=too far away 3=not necessary 4=waiting time too long 5=decision by victim not to go 6=decision by family not to go 7=not aware of service 8=other, specify

100a. Did the perpetrator go for therapy?	1=yes 2=no
100b. Was the perpetrator referred for therapy?	1=yes 2=no 3=don't know
100c. If yes, who referred? ______________________________	
101a. Did the perpetrator go on his own for therapy?	1=yes 2=no 3=don't know
101b. If no, why not?	1=therapy not available 2=too far away 3=not necessary 4=waiting time too long 5=decision by victim not to go 6=decision by family not to go 7=not aware of service 8=other, specify ______________

THERAPY - VICTIM

102a. When was the victim referred for therapy? ____year____month____day

102b. How soon after disclosure? ___ 1 week ___ 1 month ___ 3 months ___don't know

103. When did the victim go for therapy? ____year____month____day ___don't know

104a. How many times has the victim gone for therapy? _______ times

104b. If respondent is uncertain about exact number, use these categories.

1=0-3 times
2=4-7 times
3=8-12 times
4=13 or more times
5=don't know

105. Please describe the relationship between the victim and the therapist.

___ don't know

1 extremely poor	2 fair	3 good	4 very good

106a. In your opinion, did the victim have trust in the therapist? (This dimension would include issues of honesty, reliability, sincerity and general trustworthiness.)

1=yes
2=no
3=don't know

106b. If no, indicate any particular problems ____________________
____
____

107a.	In your opinion, did the therapist seem to have a positive attitude towards the victim? (This area includes issues of friendliness, likeability, sociability and warmth toward the victim).	1=yes 2=no 3=don't know

107b. If no, please indicate the reasons. ______________________________

____

____

108a.	In your opinion, did the victim have confidence in the therapist's skills and knowledge? (This particular area includes issues of experience, expertness, preparedness and skilfullness).	1=yes 2=no 3=don't know

108b. If no, please indicate why not. ______________________________

____

____

109.	Did you have contact with the victim's therapist?	1=yes 2=no
110.	Did you feel involved in the process of the victim's therapy?	1=yes 2=no
111.	Did you feel informed about what was happening to the victim?	1=yes 2=no
112a.	Would you make any suggestions for change in the therapy system?	1=yes 2=no

112b. If yes, please indicate ______________________________

____

____

113.	Did you see improvements (was the therapy helpful to the victim?)	1=yes 2=no
114.	Would you refer another victim to the therapist?	1=yes 2=no

115a. Do you think this therapist was helpful?

1=yes
2=no

115b. If yes, how? ____

____

____

PERPETRATOR - THERAPY

116a. When was the perpetrator referred for therapy? ____year____month____day

116b. How soon after disclosure? ___1 week ___1 month ___3 months ___don't know

117a. How often did the perpetrator go for therapy? ________________times

117b. If uncertain about exact number, use these categories.
1=0-3 times
2=4-7 times
3=8-12 times
4=13 or more times
5=don't know

118. In your opinion, how effective was the therapy in helping the perpetrator with his problem?

___ don't know

1	2	3	4
not at all helpful	somewhat helpful	generally helpful	extremely helpful

119. What changes have you identified in the perpetrator that may indicate improvement? ______________________________________
____

120. Please identify any concerns or problems in the provision of therapy services to the perpetrator. ____________________________
____

121. In your opinion, what changes should be made in the provision of therapy services to the perpetrators of child sexual abuse?
____
____
____

122.	Would you refer another perpetrator to the therapist?	1=yes 2=no

THERAPY - MOTHER

123a. When were you referred for therapy? ____year____month____day

123b. How soon after disclosure? ___1 week ___1 month ___3 months ___don't know

124. When did you go for therapy? ____year____month____day ___ don't know

125a. How many times have you gone for therapy? _______ times

125b. If uncertain about the exact number, use these categories.
1=0-3 times
2=4-7 times
3=8-12 times
4=13 or more times
5=don't know

126. Please describe the relationship between yourself and the therapist.

___ not applicable

1	2	3	4
extremely poor	fair	good	very good

127. How did you feel the therapist responded to you in the area of:

a. friendly, likeable, sociable, warmth

___ not applicable

1	2	3	4	5
low		medium		high

b. honest, reliable, sincere, trustworthy

___ not applicable

1 low	2	3 medium	4	5 high

c. experienced, well prepared, competent, knowledgeable

___ not applicable

1 low	2	3 medium	4	5 high

d. If there were problems in any of the above, please indicate. ______

____

____

128a.	Would you make any suggestions for change in the therapy system?	1=yes 2=no

128b. If yes, please indicate ______________________________

____

____

129.	Did you see improvements (was the therapy helpful to the you?)	1=yes 2=no
130.	Would you refer another mother to the therapist?	1=yes 2=no
131a.	Do you think this therapist was helpful?	1=yes 2=no

131b. If yes, how? ______________________________________

____

____

FAMILY THERAPY

132a. When was the family referred for therapy? ____year___month____day

132b. How soon after disclosure? ___1 week ___1 month ___3 months ___ don't know

133. When did the family go for therapy? ____year____month____day___ don't know

134a. How many times has the family gone for therapy? _______ times

134b. If respondent is uncertain about the exact number, use these categories.

1=0-3
2=4-7 times
3=8-12 times
4=13 or more times
5=don't know

135. Please describe the relationship between the family and the therapist.

___ not applicable

1 extremely poor	2 fair	3 good	4 very good

136. How did you feel the therapist responded to the family in the area of:

a. friendly, likeable, sociable, warmth

___ not applicable

1 low	2	3 medium	4	5 high

b. honest, reliable, sincere, trustworthy

___ not applicable

1	2	3	4	5
low		medium		high

c. experienced, well prepared, competent, knowledgeable

___ not applicable

1	2	3	4	5
low		medium		high

d. If there were problems in any of the above, please indicate. ______

____

____

137a. Would you make any suggestions for change in the therapy system for families? 1=yes 2=no

137b. If yes, please indicate ______________________________

____

____

138a. Did you see improvements (was the therapy helpful to your family)? 1=yes 2=no

138b. If yes, please indicate. ______________________________

____

____

139. Would you refer another family to the therapist? 1=yes 2=no

140a. Do you think this therapist was helpful? 1=yes 2=no

140b. If yes, how? ______________________________

____

GENERAL SUPPORT AND EDUCATION

141a.	Did anyone explain to you the possible impact of child sexual abuse on your child?	1=yes 2=no

141b. If yes, who? ____________________________________

142a.	Did anyone offer you any information on how to approach your child about what happened to her?	1=yes 2=no

142b. If yes, who? ____________________________________

143a.	Did anyone offer you any information on how to deal with or react to the perpetrator?	1=yes 2=no

143b. If yes, who? ____________________________________

COMMUNITY RESPONSE

144.	Do you think people today feel child sexual abuse is a serious problem?	1=yes 2=no 3=don't know
145.	Do you think child sexual abuse is a serious problem?	1=yes 2=no 3=don't know
146a.	Did people outside your family find out about the sexual abuse?	1=yes 2=no 3=don't know
146b.	If yes, were they?	1=close friends 2=acquaintances 3=neighbours 4=whole community 5=school 6=relatives 7=others, _______ _______________

147. How did they know? ____

____

148a.	Did you feel they treated you differently after they found out?	1=yes 2=no 3=don't know

148b. If yes, please indicate

a. close friends

___ not applicable

1	2	3	4
very supportive	somewhat supportive	somewhat unsupportive	very unsupportive

b. acquaintances

___ not applicable

1	2	3	4
very supportive	somewhat supportive	somewhat unsupportive	very unsupportive

c. neighbours

___ not applicable

1	2	3	4
very supportive	somewhat supportive	somewhat unsupportive	very unsupportive

d. whole community

___ not applicable

1	2	3	4
very supportive	somewhat supportive	somewhat unsupportive	very unsupportive

e. school

___ not applicable

1	2	3	4
very supportive	somewhat supportive	somewhat unsupportive	very unsupportive

f. relatives

___ not applicable

1	2	3	4
very supportive	somewhat supportive	somewhat unsupportive	very unsupportive

149. Did you feel they treated the victim differently?
1=yes
2=no
3=don't know

150. What, if anything, do you think needs to be done to have "others" be more understanding and supportive to families and victims of child sexual abuse?

151a. Please identify any negative reactions to the family.

151b. Please identify any negative reactions to the victim.

152a. Please identify any positive reactions to the family.

152b. Please identify any positive reactions to the victim.

SUMMARY/EVALUATION

153. I'd like you to think back over all you've been through since your child disclosed the sexual abuse. This would include the disclosure, investigation, interviews, interventions, court, therapy and so forth.

a. What's been the most difficult part of this for you?

____

____

b. What's been the most helpful to you?

____

____

154. Are you having any family concerns or problems? 1=yes
If yes, please identify ______________________ 2=no

____

155. Are you still in therapy? 1=yes
2=no

156. Is the victim still in therapy? 1=yes
2=no

157a. Please identify any emotional or behavioural problems that the victim may still have. ______________________

____

____

157b. Are the problems related to the sexual abuse? 1=yes
2=no
3=not sure

158. Please rate how the victim is doing.

1 extremely poor	2 fair	3 good	4 very good

159. What family concerns or problems do you have now? ________________

____

____

160. Thinking back over all of the different people that you've come in contact with as a result of the sexual abuse problem, I'd like to know if the way that other people responded to you helped or made things worse for you. I'm going to read a list of people who you may have come in contact with and I'd like you to rate them as to whether they helped a lot, helped a little, didn't really help at all or made things worse. You may not have been involved with all of these people, so rate only the ones with whom you've been in contact.

	really helped (helped a lot)		helped a little		didn't really help		made things worse	
	Mom	Victim	Mom	Victim	Mom	Victim	Mom	Victim
a. Other children	___	___	___	___	___	___	___	___
b. Other relatives								
___________	___	___	___	___	___	___	___	___
___________	___	___	___	___	___	___	___	___
c. Friends	___	___	___	___	___	___	___	___
d. Neighbours	___	___	___	___	___	___	___	___
e. Co-workers	___	___	___	___	___	___	___	___
f. Social workers	___	___	___	___	___	___	___	___
g. Social work investigators	___	___	___	___	___	___	___	___
h. Police	___	___	___	___	___	___	___	___
i. Counsellor/therapist	___	___	___	___	___	___	___	___
j. Court prosecutor/lawyer	___	___	___	___	___	___	___	___
k. Victim services	___	___	___	___	___	___	___	___
l. Judge	___	___	___	___	___	___	___	___
m. Doctor	___	___	___	___	___	___	___	___
n. Minister/priest	___	___	___	___	___	___	___	___
o. Others								
___________	___	___	___	___	___	___	___	___
___________	___	___	___	___	___	___	___	___

RESPONSES TO OPEN-ENDED QUESTIONS

In the space below, please fill in the responses received to any open-ended questions that were answered by the respondent. You do not need to write down the precise response but rather, you are to generate categories of responses which may be used for coding purposes.

SEX OFFENDER SURVEY

I.D. ________ D.O.B. ________ **SEX** - Male: ____
- Female: ____

RESIDENCE - West Prince: ____
- Summerside: ____
- Queens: ____
- South Kings: ____
- East Kings: ____

EDUCATION: __________ OCCUPATION: ____________________

MARITAL STATUS - Single: ____
- Married: ____
- Common Law: ____
- Divorced: ____
- Widowed: ____

SOCIO-ECONOMIC STATUS - Lower: ____
- Middle: ____
- Upper: ____

CHARGES LAID: ______________________________

OTHER CHARGES LAID: ______________________________

PLEA - Guilty: ____
- Not Guilty: ____

SENTENCE: ______________________________

____

DATE OF OFFENCE: __________ DATE OF CHARGE: __________ DATE REFERRED TO PROBATIONS: __________

VICTIM

NOTE: If more than one victim, fill out Victim and Sexual Offence sections for each victim on a separate form.

NUMBER OF VICTIMS: ____ AGE: ____ **SEX** - Male: ____
- Female: ____

RELATIONSHIP TO VICTIM:

Child Victim - Natural Parent: ____
- Step-Parent: ____
- Grandparent: ____
- Sibling: ____
- Other Relative: ____
- Person in Position of Trust: ____
- Friend/Acquaintance: ____
- Babysitter: ____
- Stranger: ____
- Other: ____

Adult Victim - Stranger: ____
- Acquaintance: ____
- Boyfriend: ____
- Spouse: ____
- Other Relative: ____

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SEXUAL OFFENCE

TYPE OF SEXUAL MISCONDUCT (Check all appropriate)
- Fondling/Touching: _____
- Oral Genital: _____
- Oral Anal: _____
- Penetration* - Digital: _____
  - Vaginal: _____
  - Penile: _____
  - Anal: _____
- Exhibitionism: _____
- Obscene Phone Calls: _____
- Voyeurism: _____

* "A" = Attempted
"C" = Completed

DEGREE/TYPE OF COERCION/VIOLENCE (Check all appropriate)
- Use of Physical Force: _____
- Use of Physical Threat: _____
- Use of Verbal Threat: _____
- Psychologically Oriented Manipulation: _____
- Rape: _____
- No Direct Involvement: _____

NUMBER OF ASSAULTS: _____

DURATION
- Up to 6 Months: _____
- 6 Months to 1 Year: _____
- 2 to 3 Years: _____
- More than 3 Years: _____

USE OF ALCOHOL DURING OFFENCE
- Yes: _____
- No: _____

USE OF DRUGS DURING OFFENCE
- Yes: _____
- No: _____

OFFENDER'S CRIMINAL HISTORY

PREVIOUS SEX-RELATED OFFENCES KNOWN BUT NOT INVESTIGATED
- Yes: _____
- No: _____

If Yes, Describe: ____________________

PREVIOUS SEX-RELATED OFFENCES INVESTIGATED BUT NO CHARGES LAID
- Yes: _____
- No: _____

If Yes, Describe: ____________________

WAS OFFENDER SENT FOR TREATMENT IN LIEU OF CHARGES - Yes: _____
- No: _____

If Yes, Describe: ____________________

____

PREVIOUS SEX-RELATED CHARGES LAID - Yes: _____
- No: _____

If Yes, Describe: ____________________

____

PREVIOUS TREATMENT FOR SEX-RELATED CHARGES - Yes: _____
- No: _____

If Yes, Describe: ____________________

____

PREVIOUS CRIMINAL CHARGES LAID - Yes: _____
- No: _____

If Yes - In Last 2 Years: _____
- In Last 5 Years: _____
- In Last 10 Years: _____
- More than 10 Years Ago: _____

Describe: ____________________

____

CURRENT CHARGES/TREATMENT

SEX OFFENDER'S FAMILY RESPONSE TO CHARGES - Denial of Offence: _____
- Denial of Seriousness of Offence: _____
- Blaming the Victim: _____
- Acceptance of Seriousness of Offence: _____
- Not Known: _____

DID OFFENDER RECEIVE AN ASSESSMENT AS A RESULT OF THIS CHARGE - Yes: _____
- No: _____

If Yes, What Agency: ____________________

From Whom: ____________________

TYPE OF ASSESSMENT - Mental Health: _____
- Addiction: _____
- Other: _____

DID OFFENDER RECEIVE TREATMENT AS A RESULT OF CHARGE - Yes: _____
- No: _____

If Yes, What Agency: ____

From Whom: ____

TYPE OF TREATMENT - Individual: _____
- Group: _____
- Family: _____
- Marital: _____
- Educational: _____
- Other: _____

DID OFFENDER FOLLOW THROUGH WITH TREATMENT AS REQUIRED - Yes: _____
- No: _____

HOW OFTEN DID OFFENDER SEE THERAPIST - Weekly: _____
- Bi-Weekly: _____
- Monthly: _____
- Other: _____

IN YOUR OPINION, DID THE OFFENDER DEMONSTRATE - Improvement: _____
- No Change: _____

If No Change, Identify Reasons - Offender Unmotivated: _____
- Problem Untreatable: _____
- Offender Not Seen Often Enough: _____
- Offender Not Seen Long Enough: _____
- Needed More Specialized Resource: _____
- Other: _____

OVER HOW LONG A PERIOD WAS OFFENDER SEEN BY THERAPIST - 1 to 3 Months: _____
- 3 to 6 Months: _____
- 6 to 12 Months: _____
- Longer than 12 Months: _____

HOW OFTEN DID OFFENDER SEE PROBATION OFFICER - Weekly: _____
- Bi-Weekly: _____
- Monthly: _____
- Other: _____

IS OFFENDER CURRENTLY ON PROBATION CASELOAD - Yes: _____
- No: _____

IDENTIFY ANY SYSTEM RESPONSE FACTORS THAT MAY INCREASE PROBABILITY OF THIS OFFENDER REPEATING
- No Court-Mandated Treatment: _____
- Poor Coordination Between Services: _____
- Assessment/Treatment Not Available: _____
- Insufficient Assessment/Treatment Services: _____
- Assessment/Treatment Not Designed Properly: _____
- Other: _____

DID OFFENDER HAVE HISTORY OF
- Drug Problems: _____
- Alcohol Problems: _____
- Emotional/Psychological Problems: _____
- Family/Marital Problems: _____
- Employment Problems: _____
- Victim of Sexual Abuse: _____
- Victim of Physical Abuse: _____

COMPARED TO YOUR FIRST CONTACT WITH THE OFFENDER, HOW WOULD YOU RATE THE OFFENDER'S LEVEL OF FUNCTIONING AT THE TIME OF YOUR LAST CONTACT
- Much Improved: _____
- Improved: _____
- No Change: _____
- Got Worse: _____
- Not Known: _____
- Not Applicable: _____

HOW WOULD YOU RATE THE POTENTIAL FOR THIS OFFENDER TO REPEAT A SEX OFFENCE
- Low: _____
- Medium: _____
- High: _____

OTHER COMMENTS:

Date ______________________

Signature ______________________

CHILD SEXUAL ABUSE NEEDS ASSESSMENT

SEX OFFENDER PROGRAM SURVEY

Name of Program: ______________________________ Date: ______________________________

____ Years of operation: ________________

Number of offenders served: _________

Check program focus:

_____ mainly adult offenders
_____ mainly adolescent offenders
_____ both adults and adolescents
_____ mainly extrafamilial offenders
_____ mainly intrafamilial offenders
_____ both intrafamilial and extrafamilial offenders
_____ sex abuse victims and offenders

Please answer the following questions based on your experience of what you would recommend in the development of a system of services concerning sex offender management and treatment.

Punishment, accountability and rehabilitation are key issues to address by the court in dealing with sex offenders. Following are a number of questions concerning some of these issues.

1. Should convicted offenders serve a jail sentence?

____ never
____ sometimes
____ almost always
____ always

Please explain: ____

____

____

____

____

____

2. What are the factors which you would consider important in determining whether there should be a jail sentence? ____________________

____

____

____

____

3. What are the factors which you would consider important in determining the length of the sentence?

____

____

____

____

____

4. In your opinion, do longer sentences have a deterrent effect on:

a. the current case being sentenced? ____yes ____no

Please explain: ____________________

____

____

____

____

b. other offenders? ____ yes ____no

Please explain: ____________________

____

____

____

5. In your opinion, do shorter sentences encourage further abuse for:

a. the current case being sentenced? ____yes ____no

Please explain: ____________________

____

____

____

____

b. other offenders? ____ yes ____no

Please explain: ____________________

____

____

____

____

6. In your opinion, are sentences for sex offenders usually

_____ too harsh
_____ just about right
_____ too lenient

7. From the perspective of treatment and rehabilitation of sex offenders, please indicate the possible effects of the following:

a. going through the court process ____________________

____

____

b. jail sentence____

8. If you were going to develop a training program for Crown Prosecutors and judges, what major areas would you cover?

a. Crown Prosecutors____

b. judges ____

9. What important assessment information should the court be aware of in sentencing an offender?

10. In working with offenders, is there a length of jail sentence which you would consider as helpful in the provision of treatment? ____ yes ____ no
If yes, no doubt this is based on certain factors related to the type of offender, nature of offense, as well as other factors.
Please indicate the length of sentence you would recommend including the main factors to be considered.

Sentence:	Factors:
Length: ________	____
	____
	____
Length: ________	____
	____
	____
Length: ________	____
	____
	____

11. From your experience with the justice system, what changes would you recommend to improve management and treatment of offenders in the following areas?
a. the law itself ____
____
____
____
____

b. police investigation ______________________________

____

____

____

____

c. Crown prosecutors ______________________________

____

____

____

____

d. judges ______________________________

____

____

____

____

e. correctional centres ______________________________

____

____

____

____

f. probation/parole officers ____________________

____

____

____

____

12. Coordination and cooperation with other systems such as police investigation, child welfare, and Crown attorneys appears to be an important element in the provision of treatment services to sex offenders. Have you developed any models, strategies or approaches to deal with this?
_____ yes _____ no. If yes, please indicate ____________________

____

____

____

____

13. In your opinion, should all offenders be required to have treatment? _____ yes _____ no
Please comment ____________________

____

____

____

____

14. What important issues should a judge address in ordering treatment for offenders?

____

____

____

15. What are the main issues which judges usually do not address in ordering treatment?

____

____

____

____

____

16. Are there groups or types of offenders and offending patterns which might predict a positive or negative outcome for treatment? _____ yes _____ no

Outcome	types of offenders	offending patterns
positive		
negative		

17. What are the most important elements required to make a program for sex offenders effective?

____

____

____

____

____

18. Please indicate the strategies you utilize in providing treatment to the following groups and any specific problems you often encounter.

a. intrafamilial offenders:

i. problems ____________________

____

____

____

ii. strategies ____________________

____

____

____

b. extrafamilial offenders:

i. problems ____________________

____

____

____

ii. strategies ____________________

____

____

____

c. offenders who are considered dangerous or violent:

i. problems ____________________

____

____

____

ii. strategies ____________________

____

____

____

d. other offenders groups:

i. problems ____________________

____

____

____

ii. strategies ____________________

____

____

____

19. Do you identify major differences between adolescent and adult offenders in:

a. how you understand and conceptualize their offenses? _____ yes _____ no

Please comment ______________________________

b. the treatment strategies you use? _____ yes _____ no

Please comment ______________________________

c. treatment outcome? _____ yes _____ no

Please comment ______________________________

20. One issues which is often discussed is around the area of family reunification in intrafamilial abuse. In your opinion, with which of the following would you most often agree?

_____ almost all offenders should be reunited with family
_____ most offenders should be reunited with family
_____ some offenders should be reunited with family
_____ very few offenders should be reunited with family

Please explain your response ____________________

21. Please indicate any preconditions you set to accept an offender into your program.

22. Are there offenders whom you think should only be treated in a closed setting?
_____ yes _____ no. Please explain ____________________

23. How do you keep offenders motivated to accept and continue in treatment? ____________________

24. Please indicate any strategies you have developed for relapse prevention. ____________________

25. Other comments ____________________

INTERVIEW SCHEDULE FOR THERAPISTS

3/04/91

CONFIDENTIALITY

NAME: ____________________________

DATE: ____________________________

A. DESCRIBING YOUR WORK: ...

1. Introduction:

When did you begin working with sexual abuse? How did you come to be involved in this work?

How do you feel about this work? Why is it important for you?

2. Personal Perspective/Model:

How would you describe your basic approach to sexual abuse? How do you understand it? Your ideas about its causes?

In your opinion, how specialized is work with sexual abuse? How important is specialized knowledge and a specific approach compared with basic, general therapeutic skills? (Do you work differently with sexual abuse survivors than with other clients?)

3. Your approach to treatment:

What are the major features of your approach to treatment? How would you characterize your orientation? Most important guiding principles? (Goals...what do you try to accomplish?)

(Clarify attitude questions)

How do you generally get your cases ... referral sources? How soon do you generally see children/families?

Assessment needs/practices: How do you determine a child's need for therapy? What factors influence your treatment planning (including practical ones)?

Who do you work with? From your experience, what do they need . . . what would you optimally like to do to meet these needs?

How long?... Frequency?...... "Ideal"? .... Discrepancy?

Mode? ....Individual? Group? Family? Preferred mode?

Nature? From crisis management ----------> supportive ----------> healing/changing? How would you describe most of your work? Preferred mode?

How important to deal with abuse issues directly? How do you manage this with the child?

Any differences between your "typical" and "ideal" approaches?

How would you like/prefer to work with sexual abuse cases? What are the reasons for the difference (e.g. clients, self, agency, systems)?

4. In your agency:

How does your work with child sexual abuse fit with the orientation of your agency? How supported? Any problems?

What opportunities for support, collegial learning exist for you within your agency? In the community? How "isolated" do you feel in your work?

B. KEY INFORMANTS ABOUT THERAPY:

1. About clients in therapy:

a. What are the key themes and issues that occur in your work with children? What are they generally like ... what do they need?

Goals for these cases? How treatable. . . what factors influence how treatable?

Level of motivation and interest? (Drop outs?)

Relationship issues with them ... cooperation, rapport, safety

How well are their needs being met?

b. What experiences have you had with the families, non-offending parents of these children? What are the key themes and issues in your work with them?

Their level of support/involvement/emotional availability to the child? How much are they a (potential) resource for support/healing? How much do you include them in treatment planning?

Generally speaking, how would you characterize the needs and issues for these families? How well do you think the needs of these families, non-offending parents are being met? How would you characterize the support system for mothers and families?

c. What experiences with offenders? Their needs, issues. How well are they met?

d. Generally speaking, how would you characterize the outcomes of the child sexual abuse cases you work with?

very poor	poor	fair	good	very good	excellent
1	2	3	4	5	6

2. What are the major problems that you have with these cases? ... the obstacles to successful treatment?

Children:

Mothers/families:

Offenders:

You/workers:

Systems:

3. What's your experience with adult survivors been like ... Major themes/needs/issues. How well are these needs being met? What are the major problems you've had in treating those cases?

4. We'd like to learn your perspective on some of the particular needs and issues for different kinds of cases (some aspect of difference in your approach, or important factors to consider in working with these cases or for developing a model).Your amount of experience with each? What are some of the problems and obstacles to successful treatment of these groups?

Intrafamilial cases (goals)

Extrafamilial cases:

Male victims (compare with females):

Very young children
|
|
|
|
|
|
V
"Unvalidated" cases:

Young offenders:

Special populations:
natives

handicapped

other

5. ABOUT THE THERAPY SYSTEM:

When you think of the entire "therapy system" that is available, how well does it generally do in meeting the therapeutic needs of kids, families ... How healed/fragile are they after therapy?

	very poor	poor	fair	good	very good	excellent
children	1	2	3	4	5	6
mothers/families	1	2	3	4	5	6
offenders	1	2	3	4	5	6
adult survivors	1	2	3	4	5	6

Major strengths?

Major weaknesses, problems? What's missing?

Generally speaking, how would you characterize the therapy community's level of skill and competence in treating ...

	very poor 1	poor 2	fair 3	good 4	very good 5	excellent 6
children (victims)	1	2	3	4	5	6
adolescent (victims)	1	2	3	4	5	6
Non-offending parents, mothers families	1	2	3	4	5	6
Offenders	1	2	3	4	5	6
Adult survivors	1	2	3	4	5	6

Please identify all therapists to whom you could comfortably refer a child for therapy.

A family:

An offender:

An adult survivor:

Do you think the sex of the therapist is an important issues in treatment of children/families/mothers/offenders? Who should do the work? Present system?

6. During therapy focused in other problems, children may report evidence of sexual abuse, or you may become concerned about the possibility of sexual abuse. Therapists often report that such undisclosed cases present particular dilemmas for them. What's your experience been like with such cases?

Are there times when you experience conflict between the legal requirement to report and your client's therapeutic needs?

How might the requirement to report affect therapy?

How do you deal with these dilemmas? ... At what level of evidence do you report?

(SCALE)

What has the impact been on the child and on therapy when you've reported incidents you learned about?

C. KEY INFORMANTS ABOUT AGENCIES:

Other agencies:

We'd also like your perspective on the other aspects of the service system involved in child sexual abuse. We'd like to learn about your experiences and perceptions of these agencies, how their work has affected your work and the children and families you work with, the strengths/weaknesses of the approach taken by the workers in these agencies (i.e. what helps and hurts) in relation to the therapeutic needs of clients and how their protocols and procedures affect children.

RCMP:

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Decisions to lay charges (when they do, when they don't)

Length of time in investigation (related to laying charges)

Where/when they do investigation interviews?

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

LOCAL POLICE:

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Decisions to lay charges (when they do, when they don't)

Length of time in investigation (related to laying charges)

Where/when they do investigation interviews?

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

CHILD AND FAMILY SERVICES:

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Referral issues (speed, understanding their priorities, practices)

Approach to validation (willingness to believe child, use her evidence)

Disempowerment/control/intrusiveness

Nature of case intervention/decisions (e.g. placement)

Availability/accessibility of services for these kids

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

CROWN PROSECUTORS:

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Preparation of child for court (adequate time?)

Willingness to use child's evidence

Use of expert witnesses (and how you think they should be used? Any experience)

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

VICTIM SERVICES:

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Court preparation/overlap with other agencies?

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

COURT:

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Delays/tim [illegible]

To court/plea:

To hearing:

To sentence:

Testimony (belief, child centred, questioning, defense practices)

How court affects therapy?

Use of therapists in pre-sentence report?

[Corrections . . . probation/parole . . . sharing of information with therapist/family]

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

PRIVATE AGENCIES (PFS, CFS):

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

RAPE AND SEXUAL ASSAULT CRISIS CENTRE:

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

ANDERSON HOUSE:

What's your experience with workers been like? Good "informal" working relationships? How broad?

Generally speaking, what do you think of how this agency handles child sexual abuse cases?

Clarifications/comments about specific areas:

sensitivity:

knowledge/skills:

communication:

cooperation:

impact:

What would you regard as the major strengths/positive aspects of the work of this agency?

For children/clients?

For you?

What would you regard as the major problems/negative aspects/difficulties of the work of this agency?

For children/clients?

For you?

Are there any conflicts or confusions about roles/authority that you experience in this agency?

WHAT'S NEEDED ... We'd like to talk with you about your ideas about what's needed and your suggestions for change in how we respond to child sexual abuse. Given your perspective as a therapist, and the problems that you've identified, what are your suggestions for change in the way this agency responds to sexual abuse?

Any other comments you would like to make about your perspective on this agency?

D. IN CONCLUSION:

1. Models and Problems:

Think now about the whole intervention system, the entire system of response to child sexual abuse, what are the three things most in need of change? What needs to be done?

1.

2.

3.

After victims' experiences with the entire intervention system, how well would you say the system provided them with what they needed to recover? (Rate how well the system is meeting their needs).

	very poor 1	poor 2	fair 3	good 4	very good 5	excellent 6
mothers/families	1	2	3	4	5	6
offenders	1	2	3	4	5	6

Generally speaking, how would you describe the impact of the experiences that victims have with the entire intervention system?

1	2	3	4	5	6	7
very positive	moderately positive	slightly positive	neither positive nor negative	slightly negative	moderately negative	very negative

Generally speaking, how would you describe the impact of the experiences that mothers/families have with the entire intervention system?

1	2	3	4	5	6	7
very positive	moderately positive	slightly positive	neither positive nor negative	slightly negative	moderately negative	very negative

In your opinion, does the system revictimize children ... If you were a victim, do you think you would disclose?

How do you think the therapeutic needs of children could best be met? What do children most require to heal/recover from sexual abuse? Your suggestions of what ought to be, ideas for a model of treatment.

How could the therapeutic needs of mothers best be met? Families?

Offenders? Connection with other treatment. Who should do it?

Adult survivors?

What particular factors about the "ruralness" of P.E.I. need to be taken into consideration in developing a model?

What role might self-help/mutual aid play in therapeutic response to sexual abuse? Ideas for this?

What's the relationship between treatment and support? Do victims/families need immediate and ongoing support? Who's in the best position to provide that? (Professionals? Self-help? Child advocate?)

Are there too many people involved in the lives of these children/families? Ideas about how there could be less?

Case management has been discussed as a central feature of a model... being a member of a team could raise some issues for therapists and other workers.

Confidentiality ... how would you feel about the full sharing of information about clients with other workers?

Conflicts about authority ... where should decision making come from?

Role relationships ... what should the role be with Child and Family Services (therapeutic vs. protective authority)

With police?

With Crown? (e.g. preparation)

With Court? (e.g. expert witnesses)

With self help (e.g. consultant)

Any other issues you would anticipate for therapists with case management models?

Mandatory treatment is an issue for some therapists. Your views?

For offenders?

For mothers with protection issues?

Is there anything else you'd like to discuss about problems with therapy/intervention and your suggestions for change?

2. Personal Reflections:

What do you find most difficult, demanding about this work?

Professionally?

Personally? What issues do you find most difficult? (e.g., anger toward offenders, sexuality issues, mistrust)

Are there "burnout" issues for you in doing this kind of work? What do you do to avoid such feelings, deal with them?

What do you need most in order to do this work (anything you'd like to elaborate on from your questionnaire?)

What are the several most important things that you have learned so far from your child sexual abuse work?

Other therapists to talk to?

CHILD SEXUAL ABUSE NEEDS ASSESSMENT
SURVEY OF THERAPISTS AND COUNSELLORS

BACKGROUND INFORMATION:

1. DATE:____year ____month ____ day   2. SEX: ____female ____ male

3. Name of the organization in which you work. ______________________________
____

4. How long have you worked there? _______ years

5. What is your position in the organization? _________________________________

6. Is your position: _____ full time _____ part time

7. How long have you been involved in doing counselling and therapy work?
______years

8. What is your highest degree of education completed?
____ high school
____ community college
____ university bachelor's degree (B.A., B.Sc., B.Ed., B.N., B.S.W.)
____ Master's
____ Doctorate

When was this degree obtained? ___________________________

9. In what field is your degree/diploma?
____ social work
____ psychology
____ nursing
____ education/counselling/guidance
____ medicine/psychiatry
____ other, please specify ______________________________

TRAINING:

10. Did you receive any training in your professional school education directly related to sexual abuse? ___yes ___no

11. If you answered "Yes" to the previous question, please describe the training experiences that you had in school related to sexual abuse. For each, please indicate the focus of the training (or areas covered), the type of format (course, section of course, seminar) and its value to you (in either your understanding of and/or practice with sexual abuse) using the following scale.

not at all valuable			moderately valuable			extremely valuable
1	2	3	4	5	6	7

Focus (areas covered) | Format (course, section of course, seminar, etc) | Value (1-7)

1. ______________________ ______________________ ________

2. ______________________ ______________________ ________

3. ______________________ ______________________ ________

4. ______________________ ______________________ ________

The following questions (#12 - #17) are concerned with both "formal" (e.g. workshops, seminars, etc.) and "informal" (e.g. supervision, peer consultation, etc.) training and learning opportunities in sexual abuse besides those you had in your professional school program.

12. Have you had any courses, workshops, seminars, conferences or any other kind of "formal" training (i.e. any structured, organized learning opportunity presented to a group) related to sexual abuse outside of your professional school education?

____ yes ____ no

13. If you answered "Yes" to the previous question, please describe the various training experiences you have had related to sexual abuse. For each experience, please indicate the focus of the training (or the areas covered), the type of format (course, workshop, conference, etc.), the source (who presented the training), the length of the training, and whether any certification was offered.

For each experience, please also rate its value to your understanding of and/or practice with sexual abuse using the scale described above (in question 11).

Please list all the training experiences you have had. Use an additional sheet if necessary.

Focus (area)	Format (e.g. course, workshop, conference)	Source	Length	Certification	Value (1-7)
				____yes ____no	
				____yes ____no	
				____yes ____no	
				____yes ____no	
				____yes ____no	
				____yes ____no	
				____yes ____no	
				____yes ____no	

14. Considering all of the "formal" training opportunities in sexual abuse that you have attended on P.E.I., please give a general rating for each of the areas listed below using the following scale.

1	2	3	4	5
poor	fair	good	very good	excellent

_____ breadth of topics
_____ relevance of topics to your interests/needs
_____ quality of presentation
_____ relevance to P.E.I.
_____ quality of follow up

15. Which of the following best describes how accessible the training opportunities available on P.E.I. have been to you?

_____ A. I've rarely gone to the training opportunities I've wanted to attend
_____ B. I've sometimes gone to the training opportunities I've wanted to attend
_____ C. I've often gone to the training opportunities I've wanted to attend
_____ D. I've very frequently gone to the training opportunities I've wanted to attend

16. If you answered the previous question with either option A ("rarely") or B ("sometimes"), please rank the following reasons for your limited participation in training in order of importance (with 1 being the most important).

_____ limited enrolment
_____ lack of time because of work demands
_____ requests turned down by agency. Please list the reasons you were given why your request was turned down ______________________________
____
____
_____ other, please specify, ______________________________
____
____
____

17. Please identify and describe any local and/or "informal" training/learning experiences you have had with colleagues in your agency or other agencies. (e.g. co-therapy, supervision, case conferences, peer consultation, etc.) related to sexual abuse.

For each experience, please indicate the number of cases, where you've had such experience, the frequency of meeting, and its value to your understanding of and/or practice with sexual abuse. (Please refer to the scale in #11.)

	Yes	No	No. of cases	Frequency	Value (1-7)
Co-therapy	___	___	____________	________	_______
Supervision	___	___	____________	________	_______
Case conferences	___	___	____________	________	_______
Peer consultation	___	___	____________	________	_______
Other, please describe ______ ________________	___	___	____________	________	_______

18. Generally speaking, which of these forms of training, "formal" or "informal" has been most valuable to you in your understanding of and/or practice with sexual abuse? Please circle the number which best describes your experience.

1	2	3	4	5	6	7
informal much more valuable	informal somewhat more valuable	informal slightly more valuable	about equally valuable	formal slightly more valuable	formal somewhat more valuable	formal much more valuable

19. In future training, which of these two orientations toward training would you find most valuable? Please circle the number that best describes your view.

1	2	3	4	5	6	7
informal much more valuable	informal somewhat more valuable	informal slightly more valuable	about equally valuable	formal slightly more valuable	formal somewhat more valuable	formal much more valuable

YOUR WORK:

20. Generally speaking, what has your average monthly caseload been during the past two years? ______________________

21. For your caseload over the past two years, please indicate the approximate percentage of your cases where you were working with the following client groups.

Adults ____ %
Adolescents ____ %
Children ____ %
Families ____ %
100%

22. Please check the two categories that best describe the work you do most often.

_____ long term intensive counselling
_____ short term intensive counselling
_____ crisis management
_____ short term supportive counselling
_____ long term supportive counselling
_____ medication maintenance
_____ case management

23. Please check the two categories that best describe the work you feel trained to do.

_____ long term intensive counselling
_____ short term intensive counselling
_____ crisis management
_____ short term supportive counselling
_____ long term supportive counselling
_____ medication maintenance
_____ case management

24. Of the total number of child cases (i.e. under 18) that you treated in the past two years, approximately what percentage involved sexual abuse?

___ less than 5% ___ 6-10% ___ 11-20% ___ 21-40% ___ 41-60% ___ more than 60%

25. Of the total number of adult cases that you treated in the past two years, approximately what percentage had histories of child sexual abuse?

___ less than 5% ___ 6-10% ___ 11-20% ___ 21-40% ___ 41-60% ___61 -80% ___ more than 80%

26. In your work, when you encounter a case of a child who has been sexually abused, which of the following are you most likely to do? Please rank the following alternatives from 1 to 4 (with 1 being your most likely course of action).

____ see the child in counselling
____ refer the child to another counsellor within my agency
____ refer the child to a counsellor at another agency
____ place the child on my waiting list to counsel her/him when time is available

27. During the past two years, please check any forms of treatment related to sexual abuse that you have provided.

___ A. individual counselling for adult offenders
___ B. group counselling for adult offenders
___ C. individual counselling for adolescent offenders
___ D. group counselling for adolescent offenders
___ E. individual counselling for child/adolescent female victims
___ F. individual counselling for child/adolescent male victims
___ G. group counselling for child/adolescent female victims
___ H. group counselling for child/adolescent male victims
___ I. individual counselling for female adult survivors
___ J. individual counselling for male adult survivors
___ K. group counselling for female adult survivors
___ L. group counselling for male adult survivors
___ M. individual counselling for non-offending parents
___ N. group counselling for non-offending parents
___ O. mother-daughter dyadic counselling in paternal incest cases
___ P. marital counselling
___ Q. family therapy (with incest cases)
___ R. family therapy (with extrafamilial cases)

28. Of the sexual abuse cases that you've been involved with during the past two years, please indicate the percentage of cases where each of the client groups listed below was your principal client.

child or adolescent victim ______ %
offender ______ %
mother (or non-offending parent) ______ %
family ______ %
100%

29. Of those forms of therapy you've provided for sexual abuse listed above (in #27),please identify the three kinds of treatment which you have provided most frequently during the past two years by using the appropriate letter. For individual types of treatment please list the approximate number of cases you've seen during this period. For group types (or families), please list the approximate number of groups (or families) seen.

Type of treatment (letter)	Number of cases (groups)
1. ________	____________________
2. ________	____________________
3. ________	____________________

30. How would you rate your understanding of the requirements for reporting sexual abuse under the Criminal Code?

1	2	3	4	5
poor	fair	good	very good	excellent

31. How much conflict have you experienced between the legal requirement to report incidents of sexual abuse and your client's therapeutic needs?

0	1	2	3	4	5	6	7
not applicable/ never experienced the problem	no conflict		some conflict		considerable conflict		extreme conflict

ASSESSING THERAPY RESOURCES:

We are trying to learn about what resources are available in the existing community for developing programs for child sexual abuse. Therefore, we would like to learn more about your level of knowledge, your personal training needs, and your level of interest in regard to particular aspects of the sexual abuse problem.

32. For each of the following areas, please indicate your current level of knowledge, using the following scale.

1 2 3 4 5 6 7

low moderate high

	low			moderate			high
A. behavioural/physical indicators of child sexual abuse	1	2	3	4	5	6	7
B. legal issues related to sexual abuse	1	2	3	4	5	6	7
C. role of other service systems, (i.e. mental health, police, social services, court) in sexual abuse intervention	1	2	3	4	5	6	7
D. investigative interviewing skills	1	2	3	4	5	6	7
E. crisis management skills	1	2	3	4	5	6	7
F. dynamics and treatment of child and adolescent victims (female)	1	2	3	4	5	6	7

	low			moderate			high
G. dynamics and treatment of child and adolescent victims (male)	1	2	3	4	5	6	7
H. dynamics and treatment of adult survivors (female)	1	2	3	4	5	6	7
I. dynamics and treatment of adult survivors (male)	1	2	3	4	5	6	7
J. dynamics and treatment of adolescent offenders	1	2	3	4	5	6	7
K. dynamics and treatment of adult offenders	1	2	3	4	5	6	7
L. dynamics and treatment of families where incest has occurred	1	2	3	4	5	6	7
M. dynamics and treatment of families where extrafamilial abuse has occurred	1	2	3	4	5	6	7
N. dynamics and treatment of non-offending parents in families with incest	1	2	3	4	5	6	7
O. dynamics and treatment of very young child victims	1	2	3	4	5	6	7

33. How would you rate your overall level of knowledge of child sexual abuse?

low			moderate			high
1	2	3	4	5	6	7

34. Please indicate the five areas of knowledge and skill listed above (in #32) that you would consider most valuable for your personal training, i.e. in which of these areas would you most like to receive further training? Please use the letters corresponding to each area and rank them in their order of importance to you.

1st. ________

2nd. ________

3rd. ________

4th. ________

5th. ________

35. How would you rate your need for more training in sexual abuse?

low			moderate			high
1	2	3	4	5	6	7

36. Using the same scale described above, please indicate your level of interest in doing each of the following kinds of work related to child sexual abuse.

	low			moderate			high
A. individual counselling for adult offenders	1	2	3	4	5	6	7
B. group counselling for adult offenders	1	2	3	4	5	6	7
C. individual counselling for adolescent offenders	1	2	3	4	5	6	7
D. group counselling for adolescent offenders	1	2	3	4	5	6	7

E. individual counselling for child/adolescent female victims	1	2	3	4	5	6	7
F. individual counselling for child/adolescent male victims	1	2	3	4	5	6	7
G. group counselling for child/adolescent female victims	1	2	3	4	5	6	7
H. group counselling for child/adolescent male victims	1	2	3	4	5	6	7
I. individual counselling for female adult survivors	1	2	3	4	5	6	7
J. individual counselling for male adult survivors	1	2	3	4	5	6	7
K. group counselling for female adult survivors	1	2	3	4	5	6	7
L. group counselling for male adult survivors	1	2	3	4	5	6	7
M. individual counselling for non-offending parents	1	2	3	4	5	6	7
N. group counselling for non-offending parents	1	2	3	4	5	6	7
O. mother-daughter dyadic counselling in paternal incest cases	1	2	3	4	5	6	7
P. marital counselling in families where parental incest has occurred	1	2	3	4	5	6	7

Q. family therapy in intrafamilial parental incest cases	1	2	3	4	5	6	7
R. family therapy in extrafamilial cases	1	2	3	4	5	6	7

37. How would you rate your overall level of interest in working in the child sexual abuse area?

low			moderate			high
1	2	3	4	5	6	7

38. Given the types of therapy listed above (in #36), please use the corresponding letters to rank what you regard as the most important priorities for treatment for sexual abuse.

1st. _______

2nd. _______

3rd. _______

4th. _______

39. If you have not been involved in much work with child sexual abuse, please identify the four most important reasons for your limited involvement and rank them in order of importance (with 1 being the most important).

____ heavy caseload
____ low level of interest in child sexual abuse work
____ little background training
____ insufficient ongoing training opportunities
____ lack of time to attend training opportunities
____ little agency support for time to spend on sexual abuse cases
____ insufficient opportunities for peer support (consultation, co-therapy)
____ little or no clinical supervision
____ cases too emotionally demanding
____ court involvement
____ cases and services too complex; require too much organization and time
____ clients are too difficult to work with (too resistive, uncooperative, too much effort for too little progress)
____ few sexual abuse cases are referred (or assigned) to me
____ other, please specify ______________________________

40. (If you answered question #39).
What would need to happen for you to become more involved in child sexual abuse work? Please identify the three most important types of factors that would contribute to your greater future involvement (and rank them in order of importance with 1 being the most important).

____ smaller caseload
____ more local training opportunities (e.g. workshops, seminars)
____ more time to attend local training opportunities
____ opportunity to attend specialized courses or training programs off of P.E.I.
____ more agency support to spend enough time on sexual abuse cases
____ more peer support in the form of consultation, co-therapy, etc.
____ more clinical supervision
____ better coordination among service agencies to reduce organizational complexity of cases
____ other reasons, please specify ______________________________

41. Please identify any ideas you have for how training in the area of child sexual abuse could be improved.

Thank you for your help. Please return this questionnaire in the envelope provided.

CHILD SEXUAL ABUSE
P.E.I. NEEDS ASSESSMENT

CASE WORKER INSTRUMENT
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

March 1, 1991
rev. 18-04-91

J.P. Kopachevsky,
Department of Sociology,
University of Prince Edward Island,
550 University Avenue,
Charlottetown, Prince Edward Island
Canada, C1A 4P3.

May 14, 1991.

Part of the P.E.I. needs assessment on child sexual abuse includes the views of service workers on victim and family needs. Most importantly, it includes your views and the information you can provide on "what the system" needs. Following an analysis of this and other data, a "new model" of intervention will be proposed to the federal and provincial government.

Much of the direction in our extensive data gathering has come from "front line" workers and supervisors in Social Services. In addition, workers and supervisors have been actively working on different aspects of a model of intervention.

Responding to sexual abuse is complex, as you know all too well. You are one of our best sources of information about the complexity of sexual abuse and the nature of your job with victims and others. We apologize for the length of the instrument, but we have tried to keep it as short as possible and cover as much "territory" as we can. With your caseloads and other paperwork, time is always precious. But we hope that we can have your cooperation in completing this instrument. We will sincerely appreciate it.

The enclosed instrument is strictly confidential. By previous contractual agreement with the federal and provincial governments and the Canadian Mental Health Association, the information and data obtained from this instrument are the sole possession of the researcher, J.P. Kopachevsky. Once the data from this instrument has been coded for statistical analysis, it will be appropriately and completely destroyed.

Other researchers in the project will, only through me, have access to statistical summaries of the data with all identifiers of the respondents removed. Respondents will be impossible to identify. The data will only be used for planning, program development and training purposes.

When you have completed the instrument, hopefully one week after you receive it, seal it in the accompanying envelope and "date stamp" the flaps of the envelope to ensure confidentiality. Please do not sign or initial the envelope. Then return it to your regional director. We will collect them from the regional centres.

We have tried to ensure as much confidentiality as is needed. We hope you will be "frank and open" with your responses and views. Thank you very much for your much needed cooperation.

Yours,
Joe Kopachevsky
J.P. Kopachevsky.

If any questions arise, please feel free to contact me directly (566-0513) or Katie McInnis (566-3034) or drop a note to me. Summaries of the instrument data will be made available to workers and supervisors in each of the Regional Services Centres.

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1. What is your current position? ____

2. In which regional office are you located?
____ O'Leary
____ Summerside
____ Charlottetown
____ Montague
____ Souris

3a. Are you in an Intake ______ or a Long Term ______ team?

3b. Are you a worker______ or a supervisor ______?

4. How many years of casework experience do you have? ___________ years

5. How many years have you been employed by the Department? _________ years

6a. What is the highest degree/diploma obtained?
______ high school
______ community college
______ B.A. or B.Sc.
______ B.S.W
______ M.A.
______ M.S.W.
______ PhD.

6b. In what discipline/area did you receive this degree? ________________________

7. What is your current age? ________ years
Sex: ______ female ______ male

8a. What is your average number of cases/month? _____ ___ /month

8b. What is the average number of services/month that you are responsible for? ________/month

8c. On average, what percent of those cases would involve a child who was sexually abused? (please check one) ____5% or less ____6-10% ____11-15% ____16-20% ____21-25% ____26-30% ____31-35% ____36-40% ____40% or more

Information on Victims:

1. a. In the past year, approximately how many cases of child sexual abuse have you been involved in? number ________

   b. Approximately how many were: females? ________
   males? ________

2. Risk level is a concept frequently used to make case work decisions. It is a very difficult concept to define because it encompasses such a wide range of factors. Based upon your experience with children who have been sexually abused in the past year, we would like to get your overall assessment of the risk levels that you have encountered with victims.

   a. Approximately what percentage were at high risk?

about 10%	about 20%	about 30%	about 40%	about 50%	about 60%	about 70%	about 80%

   b. Approximately what percentage were at moderate risk?

about 10%	about 20%	about 30%	about 40%	about 50%	about 60%	about 70%	about 80%

   c. Approximately what percentage were at low or no risk?

about 10%	about 20%	about 30%	about 40%	about 50%	about 60%	about 70%	about 80%

3. a. After victims have experienced the "system", how well do you feel the "system" (Social Services, court, therapy) has met their psychological and social needs?

very adequately	somewhat adequately	slightly adequately	slightly inadequately	somewhat inadequately	very inadequately

b. After families of victims have experienced the "system", how well do you feel the "system" has met the families needs (psychological, social)?

1	2	3	4	5	6
very adequately	somewhat adequately	slightly adequately	slightly inadequately	somewhat inadequately	very inadequately

4a. In general, how often do victims contact you for the following?

	0 never	1 very seldom	2 sometimes	3 a lot	4 quite a bit	5 always
1. information	0	1	2	3	4	5
2. advice/direction	0	1	2	3	4	5
3. emotional support	0	1	2	3	4	5
4. advocacy role (talking or contacting other people on their behalf)	0	1	2	3	4	5

4b. How often do families contact you for the following?

	0 never	1 very seldom	2 sometimes	3 a lot	4 quite a bit	5 always
1. information	0	1	2	3	4	5
2. advice	0	1	2	3	4	5
3. emotional support	0	1	2	3	4	5
4. advocacy role	0	1	2	3	4	5

4c. How often do you act in an advocacy role (talking or contacting other people on their behalf) for the victim?	0 never	1 very seldom	2 sometimes	3 a lot	4 quite a bit	5 always
4d. How often do you act in an advocacy role (talking or contacting other people on their behalf) for the family?	0 never	1 very seldom	2 sometimes	3 a lot	4 quite a bit	5 always

5. How often, after a case has been closed, do victims and families contact you for information, advice, support, etc.? (circle your response)

1	2	3	4	5	6
never	very seldom	sometimes	quite often	very often	always

6. How aware are families of the authority that a worker actually has in cases of sexual abuse?

1	2	3	4	5
never	slightly aware	somewhat aware	very aware	always aware

7. How often do you experience the conflict between keeping a trusting client relationship with a victim/family and your responsibilities to the:

a. police	0	1	2	3	4	5	6
	never	very seldom	once in a while	sometimes	quite a lot	almost always	always
b. prosecutor or court system	0	1	2	3	4	5	6
	never	very seldom	once in a while	sometimes	quite a lot	almost always	always
c. Social Services (child protection and other services)	0	1	2	3	4	5	6
	never	very seldom	once in a while	sometimes	quite a lot	almost always	always

8. People can feel rewards for their work with victims in one of three ways. They can be rewarded by (a) their supervisor/fellow workers; (b) their clients; (c) or just personally feel good about the job they did.
As you look over the last year, we are interested in how often you felt rewarded for positive outcomes in cases? (Positive outcomes would be the child is able to cope well, the family can now adequately care for the child, they do alright for themselves, etc.)

How often have you experienced positive rewards	0 never	1 very seldom	2 some of the time	3 a lot	4 most of the time	5 always
a. from your supervisor/fellow workers	0	1	2	3	4	5
b. from your clients	0	1	2	3	4	5
c. personally	0	1	2	3	4	5

d. What percent of your cases of child sexual abuse (victims/families) do you feel eventually have very negative outcomes?

10% 20% 30% 40% 50% 60% 70% 80% 90%

9. In the past year, approximately how many cases involving child sexual abuse that you have handled required an emergency type of response?

a. before validation	0	1	2	3	4	5	6	7	8 or more
b. after validation	0	1	2	3	4	5	6	7	8 or more

10. Of the follow up case plans that were put in place for children who had been sexually abused, what percentage do you feel were completed?

10% or less	about 20%	about 30%	about 40%	about 50%	about 60%	about 70%	about 80%	about 90%

11. In general can you effectively monitor or follow clients to intercept or avoid problems/difficulties, etc.? Yes____ No____
If yes, how often?

1	2	3	4
very seldom	sometimes	a lot of the time	most of the time

12. How often do you feel frustrated by what you wanted to do for a victim/family and what you could actually do for them?

1	2	3	4	5
never	very seldom	sometimes	a lot of the time	most of the time

13. How often do you feel frustrated by what you could do for the victim/family and what they would allow you to do? (this involves their cooperation)

1	2	3	4	5
never	very seldom	sometimes	a lot of the time	most of the time

14. How much difficulty do you have in "bending the rules" for services or service delivery for children who have been abused and their families?

1	2	3	4	5
no difficulty	a little difficulty	some difficulty	a lot of difficulty	impossible to bend the rules

15. How often could you use some form of psychological assessment or evaluation of your clients who have been abused before you make decisions about the case?

1	2	3	4	5
never	very seldom	sometimes	a lot of the time	most of the time

Case Experience with Sexual Abuse Cases

In the past two years, how often did the following situations happen?

	0 never	1 very few times	2 sometimes	3 quite a few times
a. you have investigated a case in which charges were laid but the case was not prosecuted	0	1	2	3
b. you felt there was sufficient evidence but charges were not laid	0	1	2	3

	never	very few times	sometimes	quite a few times
c. cases were insufficiently investigated by Social Services	0	1	2	3
d. cases were insufficiently investigated by the police	0	1	2	3
e. case where delays in access to therapy were too long	0	1	2	3
f. the type of therapy was not adequate/ineffective	0	1	2	3
g. cases where the delays by the prosecutor or court were too long	0	1	2	3
h. cases where the court process had a very negative impact on the victim	0	1	2	3
i. cases where the victim, once the case was closed, ended up in the Social Services system again	0	1	2	3
j. cases where the victim was abused again after they disclosed	0	1	2	3
k. cases where the perpetrator was a young offender	0	1	2	3

Personal Safety

Workers may become concerned for their own personal safety in cases involving child sexual abuse due to threats from offenders or others.

1. In the past few years, can you approximate the number of times you have been threatened during a child sexual abuse case?
   Number of times _____________

2. Even if a verbal threat was not made, how often have you felt threatened or concerned for your safety?

0	1	2	3	4	5
never	seldom	sometimes	a lot	most of the time	always

3. In comparison to other child welfare cases, how much greater are your concerns for your personal safety during child sexual abuse cases?

1	2	3	4	5
no more than other cases	a little more concerned	somewhat more concerned	a lot more concerned	very concerned

4. When you feel threatened or concerned about your personal safety, how much support do you usually get from:

a. your supervisor	1 none	2 a little	3 some	4 a lot deal	5 a great
b. the police	1 none	2 a little	3 some	4 a lot deal	5 a great

5. Do your concerns for your personal safety affect how you handle a case of child sexual abuse? _____yes _____no

If yes, how much?	1	2	3	4
	a little	some	a lot	great deal

Confidentiality:

Confidentiality is always a major problem in handling, coordinating and delivering services to children who have been sexually abused. The next series of questions will focus on your experience with the issue of confidentiality.

1. How frequently has confidentiality been a problem that affected how you investigated a complaint of child sexual abuse?

0	1	2	3	4	5
never	very seldom	sometimes	quite a few times	most of the time	always

2. How frequently has confidentiality been a problem that affected how you provided services to victims of sexual abuse?

0	1	2	3	4	5
never	very seldom	sometimes	quite a few times	most of the time	always

3. How frequently has confidentiality been a problem that affected how the other agencies (schools, therapy) cooperated with you in reporting a complaint?

0	1	2	3	4	5
never	very seldom	sometimes	quite a few times	most of the time	always

Protocols

Protocols are essential to the coordination of investigations os child sexual abuse cases. The degree to which agencies follow these protocols can significantly influence a case and its outcome. However, the protocols themselves may be problematic. The following questions are concerned with the difficulties you have experienced with protocols.

1. a. How much difficulty have you had operating within the guidelines of the current protocols for child sexual abuse cases?

1	2	3	4	5
no difficulty	minor difficulty	some difficulty	a lot of difficulty	major difficulty

b. If there has been difficulty, for what reasons? ______________________________

____

____

2. a. Over the past few years, to what degree have you personally followed the existing protocols in child sexual abuse cases?

0	1	2	3	4
never	once in a while	some of the time	a lot of the time	most or all of the time

b. If you haven't followed the existing protocols, why haven't you followed them?

____

____

____

Police

The next few questions concern your experience with the police in Prince Edward Island during your investigations of complaints of child sexual abuse. Although your experience with individual officers will vary, we would like to ask specific and general questions.

1. a. In general, to what degree do the police understand the current protocols?

1	2	3	4
no understanding	a little understanding	a lot of understanding	complete understanding

b. In general, to what degree have they followed the current protocols?

1	2	3	4	5
never	once in a while	about half the time	most of the time	always

c. How much variation have you experienced in the understanding of the protocols by different officers?

1	2	3	4
no variation	a little variation	some variation	a lot of variation

d. How much variation have you experienced in the following of protocols by different officers?

1	2	3	4
no variation	a little variation	some variation	a lot of variation

7. In your experience, what are the usual results of not following protocols?

a. ____

b. ____

c. ____

d. ____

Reporting Child Sexual Abuse

1. In your experience, how often have the following agencies followed the mandatory reporting requirements of child sexual abuse to Child and Family Services?

	0 never	1 very seldom	2 sometimes	3 quite a bit	4 very often	5 always
a. physicians/hospital personnel	0	1	2	3	4	5
b. school personnel	0	1	2	3	4	5
c. police	0	1	2	3	4	5
d. therapists	0	1	2	3	4	5
e. community support groups (Rape and Sexual Assault, AA, Addiction Services, etc)	0	1	2	3	4	5
f. volunteer organizations (Big Brothers/Sisters, Scouts, sports, etc)	0	1	2	3	4	5
g. daycare/kindergarten personnel	0	1	2	3	4	5
h. churches/church organizations	0	1	2	3	4	5
i. other government agencies	0	1	2	3	4	5

2. In your experience, to what degree do agencies, other than the police, understand the authority of Social Services in cases of child sexual abuse?

They have:

0	1	2	3	4
no understanding	very little understanding	some understanding	a lot of understanding	fully understand

3. In your experience with other agencies, how realistic are their expectations of what Social Services can do in child sexual abuse allegations or cases?

1	2	3	4	5	6
very unrealistic	somewhat unrealistic	slightly unrealistic	slightly realistic	somewhat realistic	very realistic

Risk Level of Child

There are no "set" formulas for determining the risk level of a child. We have compiled a list of the many factors that child welfare workers will use to determine the level of risk. They can vary in the level of importance that a worker will place on them depending on the situation with the child, the family and service availability.

We would ask you to go through the very difficult task of rating the importance of these criteria to you when you try to determine a child's risk level. We would ask you to think generally how important each of these factors are to you in determining risk. We realize that they all can be important, but we are interested in "how" important. Please read over the list first and then respond to each item. If you think of others, please add them. Your patience with this question will be greatly appreciated and very useful.

	0	1	2	3	4	5	6	7	8	9	10
	no importance		little to none		somewhat important		pretty important		very important		extremely or most important
How important are the following criteria to you when you determine the risk level of a child?											
a. age of the child	0	1	2	3	4	5	6	7	8	9	10
b. sex of the child	0	1	2	3	4	5	6	7	8	9	10

	no importance 0	1	little to none 2	3	somewhat important 4	5	pretty important 6	7	very important 8	9	extremely or most 10
c. the presence of any physical injury or violence	0	1	2	3	4	5	6	7	8	9	10
d. nature of physical injury or violence	0	1	2	3	4	5	6	7	8	9	10
e. severity of the sexual abuse	0	1	2	3	4	5	6	7	8	9	10
f. duration of the sexual abuse	0	1	2	3	4	5	6	7	8	9	10
g. how recently the abuse happened	0	1	2	3	4	5	6	7	8	9	10
h. history of past incidents of abuse or injury	0	1	2	3	4	5	6	7	8	9	10
i. the vagueness of parental explanation or response to the complaint	0	1	2	3	4	5	6	7	8	9	10
j. the child's response/explanation	0	1	2	3	4	5	6	7	8	9	10
k. the child's emotional state/development	0	1	2	3	4	5	6	7	8	9	10
l. the child's current behaviour	0	1	2	3	4	5	6	7	8	9	10
m. the home situation of child	0	1	2	3	4	5	6	7	8	9	10

	no importance		little to none		somewhat important		pretty important		very important		extremely or most important
n. the emotional stability of parents	0	1	2	3	4	5	6	7	8	9	10
o. the cooperation of victim	0	1	2	3	4	5	6	7	8	9	10
p. the cooperation of parent(s)	0	1	2	3	4	5	6	7	8	9	10
q. the parent(s) willingness to believe allegation	0	1	2	3	4	5	6	7	8	9	10
r. the parent(s) desire to help or protect	0	1	2	3	4	5	6	7	8	9	10
s. other, ______________________	0	1	2	3	4	5	6	7	8	9	10
t. other, ______________________	0	1	2	3	4	5	6	7	8	9	10

We would appreciate your taking a few minutes to look over these factors and identify which four you feel are the most important from the previous list.

1. ____

2. ____

3. ____

4. ____

Referrals

1. In the past year, approximately how many children who have been sexually abused have you referred for therapy? number _________

2. In these cases, how often have you also referred family members?

0	1	2	3	4	5	6
none	very few	some	about half	quite a few	most	all

3. When you make referrals for therapy, what two agencies or private therapists do you make most of your referrals to?

Agency or therapist A (name)____

Agency of therapist B (name)____

4. In the two agencies or therapists that you mentioned in question 3, is there a therapist you personally contact most of the time? (Note: If you mentioned a private therapist's name, please check yes.)

Agency or therapist A. Yes____ No____

Agency or therapist B. Yes____ No____

5. How familiar are you with the operating philosophy or approach toward therapy that these agencies or therapists have toward victims and families?

Agency or therapist A.	1 not familiar	2 slightly familiar	3 somewhat familiar	4 very familiar
Agency or therapist B.	1 not familiar	2 slightly familiar	3 somewhat familiar	4 very familiar

6. How well has this agency or therapist fit your client's needs?

Agency or therapist A.	1 slightly	2 somewhat	3 a lot	4 fully
Agency or therapist B.	1 slightly	2 somewhat	3 a lot	4 fully

7. What is your overall satisfaction with the client outcomes from this agency or therapist?

Agency or therapist A.	1 slightly satisfied	2 somewhat satisfied	3 very satisfied	4 totally satisfied
Agency or therapist B.	1 slightly satisfied	2 somewhat satisfied	3 very satisfied	4 totally satisfied

8. What are the major problems you experience in making referrals for children who have been sexually abused?

Problems: a. ____

b. ____

c. ____

d. ____

9a. After a child has been referred for therapy, do you have any influence on the services provided to that client? Yes_____ No_____

b. If yes, how much?

0	1	2	3	4
none	very little	some	a lot	quite a lot

c. If you make referrals for services outside Social Services (e.g. Anderson House, support groups), do you have any influence on what services are provided to that client? Yes_____ No_____

d. If yes, how much?

0	1	2	3	4
none	very little	some	a lot	quite a lot

10. After making a referral, how much written communication (reports, reviews, problems, outcomes, etc.) do you typically receive from:

a. therapist/agency	0 none	1 very little	2 some	3 a lot	4 quite a lot
b. services within Social services	0 none	1 very little	2 some	3 a lot	4 quite a lot
c. services outside Social services	0 none	1 very little	2 some	3 a lot	4 quite a lot

11. After making a referral, how much verbal communication do you typically have with:

a. therapist/agency?	0 none	1 very little	2 some	3 a lot	4 quite a lot
b. services within Social services?	0 none	1 very little	2 some	3 a lot	4 quite a lot
c. services outside Social services?	0 none	1 very little	2 some	3 a lot	4 quite a lot

12. In making a decision about the referral of a child who has been sexually abused, a number of factors have to be considered before a referral is made.
Below is a list of factors, please rank them in terms of importance in making a referral (1 the most important to 4 the least important)

Factors:	Rank:
nature of victim's needs	______
competence of the therapist	______
availability or waiting list	______
past experience or trust of the therapist	______
suitability of the therapy	______
other, please specify ______________________________	______

Young Offenders in Child Sexual Abuse Cases
(under 18 years old)

1. In the past two years, approximately how many of your cases of child sexual abuse involved an offender who was under 18 years old? (circle the approximate number)

   0 1 2 3 4 5 6 7 8 or more

2. Of those cases in the past two years that involved a young offender, approximately how many were charged?

   a. offenders who were from 11 to 13 years old? (circle the approximate number)

   0 1 2 3 4 5 6 7

   b. offenders who were from 14 to 17 years old? (circle the approximate number)

   0 1 2 3 4 5 6 7

3. In these cases, did you open a PT file for any of the young offenders?
   Yes______ No ______

4. Are adequate therapeutic services available for this group? Yes_____ No_____

5. To what extent do you agree or disagree that an adolescent offender should be charged in order to get access to treatment?

1	2	3	4	5
strongly disagree	somewhat disagree	neither agree nor disagree	somewhat agree	strongly agree

6. How much responsibility for cases involving young offenders has

a. the Department of Justice taken:	1 none	2 very little	3 some	4 a lot	5 all
b. the Department of Social Services taken:	1 none	2 very little	3 some	4 a lot	5 all

Workers, in many fields, are apprehensive about becoming involved in child sexual abuse cases for a wide variety of reasons. Little or no research exists in the area. However, this type of information is critical in providing training and devising a model of intervention.

The next series of questions concern a worker's comfortableness with child sexual abuse cases and the reasons they are or are not willing and under what conditions they would be. Again, all this information is confidential.

1. a. How comfortable are you with cases that involve child sexual abuse? cases?

0	1	2	3	4	5
never comfortable	hardly ever comfortable	comfortable some of the time	comfortable a lot of the time	comfortable most of the time	always comfortable

If you answered (some of the time, hardly ever, or never) in the previous question, please complete the next question. If not, go to part c.

b. Please list the major reasons why you may be unwilling to become involved in cases of child sexual abuse. Then rank them from the most important to the least important. If you have only two or three reasons, that's fine. Only rank those reasons from most to least important.

Reasons: ______________________________ most important

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ least important

c. If you answered a lot of the time, most or always, please answer the next question.

Please list some of the major reasons why you feel "comfortable" with sexual abuse cases and rank them from the most to the least important.

1. ______________________________ most important
2. ______________________________ __________
3. ______________________________ __________
4. ______________________________ least important

Victims - Disclosure

Cases involving child sexual abuse may be based on accidental or purposeful disclosures by the victim. Accidental disclosures occur in a variety of ways, but the sexual abuse is revealed in something they said, sexualized behaviour, something shared with a friend - not a deliberate effort, it occurs by chance. What is not deliberate is very difficult to determine.

1. In your experience, what percent of your investigations have been based on "accidental" disclosures?

1	2	3	4	4	6	7	8
10% or less	20%	30%	40%	50%	60%	70%	80% or more

2. In your experience, what percent of your cases involved a full disclosure in your initial interview with the child?

1	2	3	4	5	6	7	7
10% or less	20%	30%	40%	50%	60%	70%	80% or more

3. Children, whether the disclosure was accidental or purposeful, will sometimes deny an accidental disclosure or recant a purposeful one. In your experience, how often do children:

a. deny an accidental disclosure?	0	1	2	3	4	5	6
	none	very few	some	about half	many	quite a few	all
b. recant a purposeful disclosure?	0	1	2	3	4	5	6
	none	very few	some	about half	many	quite a few	all

4. Children, even if they have denied an accidental or recanted a purposeful allegation, will often reaffirm the allegation. We are interested in those that never do. How many of your cases have never been reaffirmed or continued to deny an allegation?

1	2	3	4	5	6
none	very few	some	about half	many	most

5. The reason for a child denying, recanting or failing to provide sufficient details are complex and very difficult to determine. In your experience, how often have you felt the following reasons "caused" the denial or recanting?

	0 never	1 once in a while	2 sometimes	3 about half	4 often	5 very often
a. pressure from the offender	0	1	2	3	4	5
b. pressure from the family (non-offending)	0	1	2	3	4	5
c. fear of separation from the family	0	1	2	3	4	5
	never	once in a while	sometimes	about half	often	very often
d. publicity (other people will know)	0	1	2	3	4	5
e. fear of judicial outcomes for offender	0	1	2	3	4	5
f. fear of breakup of the family	0	1	2	3	4	5
g. nature/method of the investigation by the police and Child and Family Services	0	1	2	3	4	5
h. lack of trust in the investigators	0	1	2	3	4	5
i. self-imposed pressure (guilt, they'll be alright on their own)	0	1	2	3	4	5

Training

1. Have you had enough training and experience to effectively handle all the cases of child sexual abuse that were assigned to you? Yes____ No____

2. Over the past two years, in what percentage of your cases of child sexual abuse did you really feel you had the necessary skills, experience, etc to handle the case effectively?

I feel I had enough skill and experience to effectively handle

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100% of the cases assigned to me.

3. Workers will gain knowledge and skills in case work from a lot of different sources. We would like you know how much of your skills in child sexual abuse come from the following sources:

	3a. How much training or experience in child sexual abuse have you had from the following sources?				3b. If available, how much of this type of training would you want?			
	0 none	1 some	2 a lot	3 a great deal	0 none	1 a little	2 some	3 a lot
a. formal training (university, classroom)	0	1	2	3	0	1	2	3
b. on the job training (in-service)	0	1	2	3	0	1	2	3
c. work association with very experienced people	0	1	2	3	0	1	2	3
d. observation and review of other workers	0	1	2	3	0	1	2	3
e. review of my own work by others	0	1	2	3	0	1	2	3
f. technical or practical direction by your supervisor	0	1	2	3	0	1	2	3
g. observation and review of other people working in child sexual abuse outside our system	0	1	2	3	0	1	2	3

5. On average, how many hours per week on the job do you spend in some kind of reading or training to keep current or to up-grade your skills for your job?

1	2	3	4	5
less than 1 hour/week	1-3 hours	4-6 hours	7-9 hours	10 + hours

off the job

6. On average, how many hours per week off the job do you spend in some kind of reading or training to keep current or to upgrade your skills for your job?

1	2	3	4	5
less than 1 hour/week	1-3 hours	4-6 hours	7-9 hours	10 + hours

Work Skills

Please rate your skills in the following areas according to the following scale:

	1 very poor	2 poor	3 fair	4 good	5 very good	6 excellent
a. recognizing the signs or indicators of sexual abuse	1	2	3	4	5	6
b. collecting evidence related to:						
1. CFS Act	1	2	3	4	5	6
2. Criminal Act	1	2	3	4	5	6
c. interviewing children	1	2	3	4	5	6
d. interviewing families	1	2	3	4	5	6
e. using your authority	1	2	3	4	5	6
f. cooperating in team settings	1	2	3	4	5	6
g. assessing a child's behaviour/emotional development	1	2	3	4	5	6
h. assessing parental capacity	1	2	3	4	5	6
i. assessing the parent/child relationship	1	2	3	4	5	6

	very poor	poor	fair	good	very good	excellent
j. assessing the child's needs	1	2	3	4	5	6
k. assessing the parent's protective response	1	2	3	4	5	6
l. assessing the offender's response	1	2	3	4	5	6
m. determining vulnerability of child (risk to child)	1	2	3	4	5	6
n. case planning	1	2	3	4	5	6
o. coordination within the agency	1	2	3	4	5	6
p. coordination outside of the agency	1	2	3	4	5	6

Case Decisions:

Child sexual abuse cases require a great amount of decision making, many times in crisis or emergency situations. Workers will have varying degrees of difficulty with different types of decisions due to the complexity of the case, the amount of evidence, experience, training, emotions, etc.

We would like to present you with a list of decision areas and ask you to generally estimate how much difficulty you have had in making decisions in each of these areas. If you have (a lot or extreme difficulty), please provide us with a few words why.

This information will be very valuable to us in planning and training.

How much difficulty have you had in decisions related to:	0 no difficulty	1 minor difficulty	2 some difficulty	3 a lot of difficulty	4 extreme difficulty	If a lot or extreme difficulty, why?
1. when to investigate a complaint of abuse	0	1	2	3	4	
2. how to investigate a complaint of abuse	0	1	2	3	4	
3. how "far" to investigate a complaint of abuse	0	1	2	3	4	
4. validating or not validating a complaint	0	1	2	3	4	
5. determining the risk level of a child	0	1	2	3	4	
6. removing a child from the home	0	1	2	3	4	
7. having an offender removed from the home	0	1	2	3	4	
8. determining the safety of a child with non-offending parent(s)	0	1	2	3	4	

How much difficulty have you had in decisions related to:	0 no difficulty	1 minor difficulty	2 some difficulty	3 a lot of difficulty	4 extreme difficulty	If a lot or extreme, why?
9. approaching the court for temporary or permanent applications	0	1	2	3	4	
10. determining an appropriate placement	0	1	2	3	4	
11. case plans (including types of service)	0	1	2	3	4	
12. how long a service should last	0	1	2	3	4	
13. priorizing my involvement in cases	0	1	2	3	4	
14. making referrals for therapy:						
a. when	0	1	2	3	4	
b. to whom	0	1	2	3	4	
15. how much to monitor or "push" a client to affect change	0	1	2	3	4	
16. how much guidance you give beyond normal casework	0	1	2	3	4	
17. closing a case	0	1	2	3	4	

Workload

1. When you don't have enough time to give to your clients, is it because?

(circle the number which best fits your response)	5 always	4 very often	3 often	2 sometimes	1 seldom	0 never
a. you've been assigned too much work?	5	4	3	2	1	0
b. there are changes in your incoming case demand?	5	4	3	2	1	0
c. it takes more time because you don't have enough skills or experience?	5	4	3	2	1	0
d. poor internal coordination/ cooperation?	5	4	3	2	1	0
e. poor external coordination/ cooperation?	5	4	3	2	1	0
f. there are changes in the demands of your clients?	5	4	3	2	1	0
g. there are changes in the demands the families?	5	4	3	2	1	0
h. repriorizing affected my ability to do a proper follow up?	5	4	3	2	1	0

2. Over the past year, how much of your time with child sexual abuse cases involved the following?
(please try to make your responses to these items (a,b,c) add up to 100 %)

a. doing meaningful work that would help the client directly	none	about 10%	about 20%	about 30%	about 40%	about 50%	about 60%
b. doing less than meaningful work that might or indirectly help the client	none	about 10%	about 20%	about 30%	about 40%	about 50%	about 60%
c. doing non-meaningful work, that was or would be of no help to the client	none	about 10%	about 20%	about 30%	about 40%	about 50%	about 60%

100%

Time in Coordination

We realize that activities in Social Services vary a great deal from day to day. However, during the past few weeks, on the average how many hours did you normally send in each of the following general activities. Your figures probably will add up to more than 8 hours, that's fine!

(read the list and start anywhere)	Regular caseload average hours/day	In cases of child sexual abuse would you do more or less of this activity?
1. How much time did you spend doing the following:		
a. keeping records of my activities and completing MIS reports, etc.	____________ hr/day	more_____ less_____
b. talking to my supervisor/director about my activities, case plans, etc.	____________ hr/day	more_____ less_____
c. talking informally to people about my cases or activities	____________ hr/day	more_____ less_____
d. coordinating my work with other members of my unit, discussing and solving problems encountered with other units or services, performing office-wide projects and activities	____________ hr/day	more_____ less_____
e. coordinating work activities with people in the region office, issuing requests, responding to directives and working out issues	____________ hr/day	more_____ less_____
f. responding to the central office	____________ hr/day	more_____ less_____
g. coordinating activities with other organizations outside of Social Services, providing information, arranging services, monitoring cases	____________ hr/day	more_____ less_____
h. providing direct services to clients - including information, etc.	____________ hr/day	more_____ less_____

Worker influence

The next set of items are designed to get some sense of the amount of influence workers have over decisions in their work. In the following set of questions, please indicate how much "say" you actually have in making these decisions. Not so much how much you're listened to, but how actual much influence you have in the decision.

How much influence do you have in each of the following decisions in sexual abuse cases?	0 no say	1	2 some	3	4 a lot	5	6 very great deal
Work activities:							
a. decisions about how you "handle" cases	0	1	2	3	4	5	6
b. decisions about case plans	0	1	2	3	4	5	6
c. decisions about changing how you do your work	0	1	2	3	4	5	6
	no say		some		a lot		very great deal
d. decisions about how work-related problems are solved	0	1	2	3	4	5	6
e. decisions about what you do day to day, tasks for the day	0	1	2	3	4	5	6
f. decisions about how you "deal" with other units in Social Services	0	1	2	3	4	5	6
g. decisions about how you deal with other agencies outside of Social Services	0	1	2	3	4	5	6
h. how exceptional cases are handled	0	1	2	3	4	5	6

Coordination activities:

a. decisions about how to settle difficulties or conflicts between people in your work unit	0	1	2	3	4	5	6
b. decisions about what to do when someone you depend on doesn't do their job	0	1	2	3	4	5	6
c. how work gets divided up	0	1	2	3	4	5	6
d. decisions about dealing with conflicts with other units or services within Social Services	0	1	2	3	4	5	6
e. decisions about dealing with conflicts with services outside your agency	0	1	2	3	4	5	6

Communication

How frequently during the course of an average week would you communicate, verbally or written, with the following people about job or case matters?

	Verbal Communication						Written Communication					
	1	2	3	4	5	6	1	2	3	4	5	6
	hourly	twice a day	daily	every few days	once a week	more	hourly	twice a day	daily	every few days	once a week	more
a. supervisor	1	2	3	4	5	6	1	2	3	4	5	6
b. co-workers within your team	1	2	3	4	5	6	1	2	3	4	5	6
c. co-workers outside your team	1	2	3	4	5	6	1	2	3	4	5	6
d. clients	1	2	3	4	5	6	1	2	3	4	5	6
e. families	1	2	3	4	5	6	1	2	3	4	5	6

	Verbal Communication						Written Communication					
	1	2	3	4	5	6	1	2	3	4	5	6
	hourly	twice a day	daily	every few days	once a week	more	hourly	twice a day	daily	every few days	once a week	more
f. administration - regional/central	1	2	3	4	5	6	1	2	3	4	5	6
g. co-workers outside the agency	1	2	3	4	5	6	1	2	3	4	5	6
h. administration - other agencies	1	2	3	4	5	6	1	2	3	4	5	6

As you look over the amount you communicate with people, what percent do you think is case or casework related?

10% or less	20%	30%	40%	50%	60%	70%	80%	90%

Procedures and Policies

1. How precise are the policies and procedures (excluding protocols) about how your activities are to be done in child sexual abuse cases?

1	2	3	4	5
very general	mostly general	somewhat specific	quite specific	very specific

2. How flexible are the procedures and policies for your work, other than administrative or paper work?

1	2	3	4	5
not flexible at all	very little flexibility	some	a lot	extremely flexible

3. How significant are these policies or procedures in your everyday casework?

1	2	3	4	5
not significant	a little significance	some significance	quite a bit of significance	very significant

Information:

1. When you start to investigate a complaint of sexual abuse, how much verbal and written information do you usually have?

1	2	3	4	5	6
none	very little	little but not enough	some but not enough	enough	a great deal

2. How much of this information is usually accurate?

1	2	3	4	5	6
none	very little	little but not enough	some but not enough	enough	a great deal

3. When you have to change your investigation or case plan, how often is it because of the following occurrences?

	4	3	2	1	0	
		always the time	a lot of times	some in a while	once	never
a. you didn't start with enough correct or relevant information	4	3	2	1	0	
b. some of your information was incorrect	4	3	2	1	0	
c. supervisory guidance hadn't been available	4	3	2	1	0	
d. there were changes in policy or procedures	4	3	2	1	0	
e. the availability of services changed	4	3	2	1	0	
f. inadequate case planning	4	3	2	1	0	
g. inadequate coordination with units	4	3	2	1	0	

	always	a lot of the time	some times	once in a while	never
h. inadequate coordination with other agencies	4	3	2	1	0
i. poor quality of work done by others	4	3	2	1	0
j. your case demand had changed	4	3	2	1	0
k. decisions were made outside the unit that affected what I was do	4	3	2	1	0

Personal Feelings about the Job:

Indicate the degree to which you agree or disagree with the following statements.

a. when I handle a case of child sexual abuse well, my opinion of myself goes up	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly
b. it's hard for me to care about whether work gets done in most cases of child sexual abuse	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly
c. when a victim does well, I feel really good	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly
d. when a victim doesn't do well, I feel really bad	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly
e. I feel a very high degree of personal responsibility for the work I do with victims and families	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly
f. my co-workers never give me good feedback when I do a job well	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly
g. my supervisor never gives me good feedback when I do a job well	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly
h. I am recognized when I put extra effort into a case involving sexual abuse	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly
i. our unit's reputation in Social Services for our handling of sexual abuse cases is really good	disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly

Accountability:

In cases of child sexual abuse, how much does your supervisor hold you personally accountable for your work or case decisions?

0	1	2	3	4
never	very little	some	quite a bit	very

In comparison to other cases, are you held more or less accountable for cases involving sexual abuse?

(check one) less than usual ____ about the same____ more than usual____

Satisfaction:

Next we would like to ask you some general questions about your satisfaction with your job.

How satisfied are you with the following?	1 very unsatisfied	2 somewhat unsatisfied	3 somewhat satisfied	4 quite satisfied	5 very satisfied
a. social work in general?	1	2	3	4	5

How satisfied are you with the following?	very unsatisfied	somewhat unsatisfied	somewhat satisfied	quite satisfied	very satisfied
b. your present job?	1	2	3	4	5
c. your supervisor?	1	2	3	4	5
d. your salary?	1	2	3	4	5
e. recognition for your work?	1	2	3	4	5
f. recognition for your effort?	1	2	3	4	5
g. friendliness of your co-workers?	1	2	3	4	5
h. cooperativeness of your co-workers?	1	2	3	4	5
i. career progress?	1	2	3	4	5
j. chances, here, for advancement?	1	2	3	4	5
k. the number of training or learning opportunities?	1	2	3	4	5
l. the number of challenges in the job?	1	2	3	4	5
m. the variety of my work	1	2	3	4	5

Job Feedback

1. Feedback about your job can come from two sources - others and the job itself.

a. To what extent do you rely on others (supervisors, workers) to know whether you have "handled" a case of child sexual abuse correctly?

1	2	3	4	5
never	very seldom	sometimes	a lot of the time	almost always

b. To what extent do you rely on others to know if a sexual abuse case has had a "good outcome"?

1	2	3	4	5
never	very seldom	sometimes	a lot of the time	almost always

c. During the past month, how often did your unit supervisor or director discuss your cases with you?

1	2	3	4	5
not once	once	twice	weekly	about every day

d. When your work performance was discussed, how often do you receive practical suggestions for improving your work?

1	2	3	4	5
never	very seldom	sometimes	a lot of the time	almost always

Case Conflicts:

A. How frequently are there disagreements or disputes among unit members about cases involving the sexual abuse of a child?

1	2	3	4	5	6
almost never	once in a while	sometimes	often	very often	always

Do these disputes, in comparison to other cases, occur? (check one)

____ less frequently
____ more frequently
____ about the same

B. How frequently are there disagreements or disputes between your unit and other services over cases involving sexual abuse?

1	2	3	4	5	6
almost never	once in a while	sometimes	often	very often	always

C. 1. Does the way that disputes or conflicts are settled help or hinder your work? Help____ or Hinder____.

2. How much?

1	2	3	4	5
hinders my work a lot	hinders more than helps	neither hinders nor helps	helps more than hinders	helps my work a lot

General Opinions:

The following set of statements are concerned with your opinions on a number of issues related to child sexual abuse. There are no right or wrong answers to the following statements and all the responses are confidential. Some of your responses would probably depend on the nature of cases and other circumstances. However, we would ask you to respond to these questions using a more general frame of reference.

To what extent to you agree or disagree with the following statements? (circle your response)

a. The current philosophy underlying the Child Welfare Act reflects my beliefs and values.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
b. In cases of incest, the offender should be removed from the home.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
c. Family reunification should be a goal of case plans.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
d. Whenever a complaint is investigated and there is sufficient evidence to proceed criminally, a worker should do so.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
e. All complaints involving pre-school children should be fully investigated.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree

f. If a complaint of abuse involving a pre-school child is validated, criminal prosecution should always proceed.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
g. If a case of child sexual abuse is investigated, the initial worker should have responsibility for the case until it is closed.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
h. If a case requires a long investigation (over 4 months), the initial worker should still have the main responsibility for the case.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
i. In child sexual abuse cases, children should be "rescued" immediately to prevent further abuse.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
j. In cases of intrafamilial abuse, the non-offending parent(s) should have a lot of input into the decision to proceed criminally.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
k. In cases of extrafamilial abuse, the non-offending parent(s) should have a lot of input into the decision to proceed criminally.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree

l. When children are to be interviewed in an investigation, the mandate of the Child Protection Act should take precedence over the child's needs.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
m. When children are to be interviewed in an investigation, the mandate of the Child Protection Act should take precedence over the family's needs.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
n. Workers should be willing to give responsibility for an investigation over to the police.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
o. Workers should be willing to give police as much information as they require.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
p. Victims should take responsibility for taking care of most of their own needs.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
q. A family should take responsibility for taking care of most of its own needs.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
r. After a complaint is received, every effort possible should be put into the validation of the complaint.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree

s. After a complaint has been validated, every effort possible should be put into the investigation of the complaint.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
t. In delivering services to victims or families, a worker should never "back off".	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
u. A generic model of services is adequate for dealing with cases of sexual abuse.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
v. Adolescent offenders should be charged criminally.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
w. Child sexual abuse is a serious problem.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
x. Sexual abuse is a major cause of problems that children later develop.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
y. Children who have been sexually abused need therapy.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree

z. Families involved in cases of incest require therapy.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
aa. Cases of incest require intervention by the legal system.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
bb. Children are sexually abused because their mothers failed to protect them.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
cc. Court is necessary for the future well-being of the child.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
dd. Sexual abuse of children is due to how females and males are socialized.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree
ee. Sexual abuse of children is due to our attitudes toward sexuality.	1 very strongly agree	2 strongly agree	3 somewhat agree	4 somewhat disagree	5 strongly disagree	6 very strongly disagree

THANK YOU VERY MUCH FOR YOUR COOPERATION!

AGENCY INSTRUMENT

CHILD SEXUAL ABUSE NEEDS ASSESSMENT

PRINCE EDWARD ISLAND

JUNE 1, 1991

J.P. KOPACHEVSKY
UNIVERSITY OF P.E.I.
CHARLOTTETOWN, P.E.I.
C1A 4P3

6 June 1991

Dear Director:

A needs assessment of children who have been sexually abused and their families is being conducted in Prince Edward Island. The goal of the assessment is to identify and measure the full range of needs and then develop a "new" model of intervention. At this point in time, data has been collected from children, their families, adult survivors and the wide range of people who interact with them. Many of whom are part of your agency.

Part of this assessment requires that we examine systemic needs. This includes an examination of the current nature of inter-agency relations and the coordination of agencies who respond to victims of sexual abuse and their families. The data will assist us in identifying the needs of agencies to more adequately respond to children and their families, and determine the structure of inter-relationships in which a new model must fit. The data will also help to identify the constraints to adequate delivery of services.

Enclosed is an instrument which will request data about certain aspects of your agency, your interactions with other agencies and your views on coordination problems and the development of a system of coordinated response within the Province. Data of a more qualitative nature will be collected in interviews. A short list of some of those questions are at the end of the instrument.

Since the number of agencies in P.E.I. is small, we need your cooperation in attaining an accurate picture of the entire system of inter-relationships no matter how localized they may be. I would like to assure you that this information is strictly confidential and will be used for planning and development purposes only. By agreement with the Provincial and Federal Governments, I will be in sole possession of the data. Once the instruments have been coded for computer analysis, they will be completely destroyed. In further analyses, the data will be accessed only through me. I can also assure you that your confidentiality will not be violated nor will the informal working relationships that you have developed be disrupted.

In late summer or early fall, a seminar will be organized for the participating agencies to review and highlight the data. At that time, the essential framework of the model will be discussed for your reactions and suggestions.

At the end of the instrument, you will find a short list of interview questions. I would like to discuss some of those questions, and others that you feel are very relevant, at a later time. If you have some to add to the list, please do.

Your cooperation with this aspect and later aspects of the model of intervention will be immensely appreciated. If you have any problems with the instrument, please call me at 566-0513. I will arrange for the return of the instrument.

Yours,

J.P. Kopachevsky

/jm

PART I

Agency Information

1. Agency Name: ______________________________

2. Size of Agency:

   a. approx. no. of paid professional staff: ________

   b. approx. no. of part-time professional staff: ________

   c. approx. no. of volunteer staff: ________

3. Sources of Funding:

   a. approximately what % of your annual funding comes from the Provincial Government? ________%

4. Over the past few years, what has been your agency's experience (no. of cases) with the following kinds of clients? (please approximate and circle the response closest to your estimate).

	None	A Few (1-5)	Some (6-10)	Quite a Few (11-20)	A Great Many (21 or more)
a. adult survivors of child sexual abuse	0	1	2	3	4
b. children (under 18) who have been sexually abused	0	1	2	3	4
c. family members involved in a sexual abuse case	0	1	2	3	4

5. Approximately, how many cases, all types, have been referred to your agency in the past year? ________ (general estimate).

6. Approximately, how many cases, all types, have you referred to another agency in the past year? ________ (general estimate).

7. How frequently do you encounter clients that involve child sexual abuse who have multiple problems?

	Never	Seldom	Sometimes	Quite Often	Almost Always
a. when they are child victims	0	1	2	3	4
b. when they are families	0	1	2	3	4
c. when they are adult survivors	0	1	2	3	4

8. How much of a demand do cases involving child sexual abuse place on your agency's resources and staff?

None	Minor	Some	Moderate	Large	Very Large
0	1	2	3	4	5

9. Would your agency be willing to play a role in an inter-agency network which responds to children and families involved in cases of child sexual abuse?

a. Yes ____ No ____

b. If yes, how willing do you feel your agency would be?

A Little	Some	Quite	Very
1	2	3	4

c. How much of a role? Very Minor ____ Minor ____ Somewhat Major ____ Major ____

10. If a model of inter-agency coordination of cases of child sexual abuse were adopted, which meant a case would be managed across a number of agencies, how well would this model fit into your present organizational structure and operations? I feel it would be ...

Don't Know	Not Feasible	Possibly Feasible	Somewhat Feasible	Very Feasible
0	1	2	3	4

11. Excluding Budgetary Constraints, how much flexibility do you have in the services that you provide and how you deliver them to victims and families who have been involved in a case of child sexual abuse?

Absolutely None	Very Little	Some	Moderate Amount	Considerable
0	1	2	3	4

(FOR MENTAL HEALTH AND PRIVATE AGENCIES)

12. Approximately, how many clients involving child sexual abuse have been referred to your agency by Victim Services in the past year? (Please approximate and circle the response closest to your estimate)

None	A Few (1-5)	Some (6-10)	Quite a Few (11-20)	A Great Many (21 or more)
0	1	2	3	4

PART II

System Development Problems

Based upon your experience, to what extent do you feel each of the following service, service delivery or coordination problems exist? (circle the number which best represents your opinion)

	Don't Know	Not A Problem	Very Minor Problem	Minor Problem	Moderate Problem	Considered A Problem	Major Problem
1. Therapy							
a. client access-distance to services?	0	1	2	3	4	5	6
b. client wait for services:							
1. for victims?	0	1	2	3	4	5	6
2. for families?	0	1	2	3	4	5	6
3. for offenders?	0	1	2	3	4	5	6
c. quality or adequacy of services for:							
1. victims?	0	1	2	3	4	5	6
2. families?	0	1	2	3	4	5	6
3. offenders?	0	1	2	3	4	5	6
d. availability of support services?	0	1	2	3	4	5	6
2. a. Temporary care-safe housing for victim or family?	0	1	2	3	4	5	6
b. availability of foster care?	0	1	2	3	4	5	6
3. Coordination between services:							
a. between public agencies?	0	1	2	3	4	5	6
b. between private agencies?	0	1	2	3	4	5	6
c. between public and private agencies?	0	1	2	3	4	5	6
4. Children and families "falling through cracks in the system"?	0	1	2	3	4	5	6
5. Follow-up on service effectiveness?	0	1	2	3	4	5	6

		Don't Know	Not A Problem	Very Minor Problem	Minor Problem	Moderate Problem	Considered A Problem	Major Problem
6.	Efficiency of services to victims and their families?	0	1	2	3	4	5	6
7.	Competition between agencies?	0	1	2	3	4	5	6
8.	Adequacy of funding:							
	a. for therapy/counselling for victims and families?	0	1	2	3	4	5	6
	b. for support services to victims and families?	0	1	2	3	4	5	6
9.	Case overload for services?	0	1	2	3	4	5	6
10.	Joint agency planning?	0	1	2	3	4	5	6
11.	Distinct policies from government in responding to victims and families?	0	1	2	3	4	5	6
12.	Inability to deal with multiproblem families?	0	1	2	3	4	5	6
13.	Lack of a unified public voice or advocacy for victims and families?	0	1	2	3	4	5	6
14.	Mandates of agencies are too independent or restrictive?	0	1	2	3	4	5	6
15.	Communication between agencies:							
	a. insufficient formal?	0	1	2	3	4	5	6
	b. insufficient informal?	0	1	2	3	4	5	6
16.	Inadequate knowledge and understanding of the sexual abuse problem by agencies?	0	1	2	3	4	5	6

	Don't Know	Not A Problem	Very Minor Problem	Minor Problem	Moderate Problem	Considered A Problem	Major Problem
17. Competing philosophies between agencies?	0	1	2	3	4	5	6
18. Flexibility in services?	0	1	2	3	4	5	6
19. Feedback between agencies about case outcomes?	0	1	2	3	4	5	6
20. Sharing of resources between agencies?	0	1	2	3	4	5	6
21. Lack of formal agreements between agencies for services?	0	1	2	3	4	5	6
22. Amount of autonomy that individual agency staff have?	0	1	2	3	4	5	6
23. Linking client to services, or securing services for client?	0	1	2	3	4	5	6
24. Policies or guidelines that discourage inter-agency coordination of services and support for victims and families?	0	1	2	3	4	5	6
25. How well we meet the needs of:							
a. victims of child sexual abuse?	0	1	2	3	4	5	6
b. their families?	0	1	2	3	4	5	6
26. Range of services or types of services for victims and families?	0	1	2	3	4	5	6
27. Confusion over the responsibility for clients?	0	1	2	3	4	5	6
28. Lack of advocacy for victims and families?	0	1	2	3	4	5	6

PART III

General Instructions

In the following set of questions, we will be asking you about your relationships with a list of different agencies. What we are attempting to do is identify the network of relationships and its character. Each agency listed will be answering the same questions. This will provide important development data for the model.

Please answer each of the following questions for each agency individually by writing your most accurate response in the appropriate column using the "numbered response scheme" provided after each question.

So, you will be answering the same question for every agency listed on the top of the page and working across the page.

Special Note

a) For Directors of Health and Social Services: please do not answer the question for other Regional Centers, leave those spaces blank.

b) For Mental Health Directors: although you are part of the same parent agency in Mental Health, please answer the questions for other Mental Health Agencies.

PART III

INSTRUCTIONS:

We would like your perspective on the following interagency relationships. Please answer the question for each of the other agencies individually. Write in the appropriate column the number or response category that reflects your most accurate answer to each question for each other agency.

1. How well informed are you about the goals and services provided by this agency? --->

0	1	2	3	4
NOT INFORMED	SLIGHTLY	SOMEWHAT	QUITE	VERY WELL INFORMED

2. On average, how frequently are you or your administrators in contact with this agency? --->

0	1	2	3	4	5
NO CONTACT	NEVER	A FEW TIMES	ONCE A MONTH	ONCE A WEEK	DAILY

3. How much cooperation do you receive from this agency? --->

0	1	2	3	4	5
NO CONTACT	NONE	VERY LITTLE	SOME	A LOT	VERY MUCH

4. To what extent have you had conflicts or disputes with this agency? --->

0	1	2	3	4
NO CONTACT	NEVER	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT

REGIONAL SERVICES					MENTAL HEALTH				PRIVATE AGENCIES			
Charlottetown	Summerside	Montague	O'Leary	Souris	Hillsborough Hosp.	Richmond Center	Summerside	Montague	Rape Crisis Center	Protestant F.S.B.	Catholic F.S.B.	Anderson House

5. How well are these differences worked out between your agency and the other? --->

0	1	2	3	4	5
NO CONTACT	VERY POORLY	SOMEWHAT POORLY	ADEQUATELY	WELL	VERY WELL

6. To what extent do you and your staff agree with this agency on the following items:

a. the most important needs of children who have been abused --->

0	1	2	3	4	5	6
DON'T KNOW	TOTALLY DIS-AGREE	DISAGREE QUITE A BIT	DISAGREE SOMEWHAT	AGREE SOME-WHAT	AGREE QUITE A BIT	TOTALLY AGREE

b. the most important needs of families who have been involved in sexual abuse of children --->

0	1	2	3	4	5	6
DON'T KNOW	TOTALLY DIS-AGREE	DISAGREE QUITE A BIT	DISAGREE SOMEWHAT	AGREE SOME-WHAT	AGREE QUITE A BIT	TOTALLY AGREE

REGIONAL SERVICES					MENTAL HEALTH				PRIVATE AGENCIES			
Charlottetown	Summerside	Montague	O'Leary	Souris	Hillsborough Hosp.	Richmond Center	Summerside	Montague	Rape Crisis Center	Protestant F.S.B.	Catholic F.S.B.	Anderson House

c. the nature of services and how they are provided to children and families --->

0	1	2	3	4	5	6
DON'T KNOW	TOTALLY DIS-AGREE	DISAGREE QUITE A BIT	DISAGREE SOMEWHAT	AGREE SOME-WHAT	AGREE QUITE A BIT	TOTALLY AGREE

7. How compatible is your organization's operating philosophy and goals with this agency? --->

0	1	2	3	4
NO CONTACT	NOT COMPATIBLE	SOMEWHAT COMPATIBLE	MODERATELY COMPATIBLE	VERY COMPATIBLE

8. How well does this agency perform its tasks with children and families involved in cases of child sexual abuse? --->

0	1	2	3	4	5
NO CONTACT	POORLY	FAIRLY	SOMEWHAT ADEQUATELY	MORE THAN ADEQUATELY	VERY ADEQUATELY

9. How competent do you consider its personnel? --->

0	1	2	3	4
DON'T KNOW	FEW ARE COMPETENT	SOME ARE COMPETENT	MOST ARE COMPETENT	ALL ARE COMPETENT

	REGIONAL SERVICES					MENTAL HEALTH				PRIVATE AGENCIES			
	Charlottetown	Summerside	Montague	O'Leary	Souris	Hillsborough Hosp.	Richmond Center	Summerside	Montague	Rape Crisis Center	Protestant F.S.B.	Catholic F.S.B.	Anderson House
c.													
7.													
8.													
9.													

10. To what extent is the time and effort spent with this agency to develop or maintain relationships worthwhile? --->

0	1	2	3	4	5	6
NO CONTACT	TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	MUCH EXTENT	TO A GREAT EXTENT	DON'T KNOW

11. To what extent does this agency carry out the commitments it has agreed to? --->

0	1	2	3	4	5	6
NO COMMITMENTS	TO NO EXTENT	LITTLE EXTENT	SOME EXTENT	MUCH EXTENT	TO A GREAT EXTENT	DON'T KNOW

12. Have you had any difficulty in service planning for victims or families with this agency? --->

0	1	2
NO CONTACT	YES	NO

REGIONAL SERVICES					MENTAL HEALTH				PRIVATE AGENCIES			
Charlottetown	Summerside	Montague	O'Leary	Souris	Hillsborough Hosp.	Richmond Center	Summerside	Montague	Rape Crisis Center	Protestant F.S.B.	Catholic F.S.B.	Anderson House

13. On average, if you refer a case (CSA) to this agency, how long does the client have to wait before they are seen? --->

0	1	2	3	4	5	6
NO CONTACT	NO WAIT	FEW DAYS	ONE WEEK	2-3 WEEKS	1-2 MONTHS	MORE THAN 3 MONTHS

14. Will this agency modify its waiting list, if you feel your clients' needs are urgent? --->

0	1	2	3	4
NO CONTACT	ALMOST NEVER	ONCE IN AWHILE	SOMETIMES	MOST OF THE TIME

15. Do you have any formalized agreements with this agency? --->

0	1	2	3
NO CONTACT	YES	NO	DON'T KNOW

16. Does any person from your agency sit on the Board of this agency? --->

0	1	2	3
NO CONTACT	YES	NO	DON'T KNOW

	REGIONAL SERVICES					MENTAL HEALTH				PRIVATE AGENCIES			
	Charlottetown	Summerside	Montague	O'Leary	Souris	Hillsborough Hosp.	Richmond Center	Summerside	Montague	Rape Crisis Center	Protestant F.S.B.	Catholic F.S.B.	Anderson House
13.													
14.													
15.													
16.													

17. Has any kind of interagency committee or group been established to coordinate between your agencies? --->

0 NO 1 YES 2 DON'T KNOW

18. If yes, is this committee ad hoc or a standing committee? --->

0 NO 1 AD HOC 2 STANDING COMMITTEE

19. Are the decisions made by this committee binding upon your agency? --->

0 NO 1 YES

20. Is your interaction with this agency on a routine or on a case-by-case basis? --->

0 NO CONTACT 1 ROUTINE BASIS 2 CASE-BY-CASE BASIS 3 MIXED BASIS

REGIONAL SERVICES					MENTAL HEALTH				PRIVATE AGENCIES			
Charlottetown	Summerside	Montague	O'Leary	Souris	Hillsborough Hosp.	Richmond Center	Summerside	Montague	Rape Crisis Center	Protestant F.S.B.	Catholic F.S.B.	Anderson House

21. Are you personally acquainted with another administrator in this agency? --->

0	1
NO	YES

22. Using the response framework following each question, please make general estimates for the following:

a. In general, how many referrals do you make to this agency in a year? --->

0	1	2	3	4
NONE	VERY FEW	SOME	QUITE A BIT	CONSIDERABLE NUMBER

b. In general, how many referrals do you receive from this agency in a year? --->

0	1	2	3	4
NONE	VERY FEW	SOME	QUITE A BIT	CONSIDERABLE NUMBER

c. How many child sexual abuse victims do you refer to this agency in a year? --->

0	1	2	3	4
NONE	VERY FEW	SOME	QUITE A BIT	CONSIDERABLE NUMBER

REGIONAL SERVICES					MENTAL HEALTH				PRIVATE AGENCIES			
Charlottetown	Summerside	Montague	O'Leary	Souris	Hillsborough Hosp.	Richmond Center	Summerside	Montague	Rape Crisis Center	Protestant F.S.B.	Catholic F.S.B.	Anderson House

d. How many child sexual abuse victims do you receive as referrals from this agency? --->

0	1	2	3	4
NONE	VERY FEW	SOME	QUITE A BIT	CONSIDERABLE NUMBER

e. How many family members, in general, who were not offenders, do you refer to this agency?-->

0	1	2	3	4
NONE	VERY FEW	SOME	QUITE A BIT	CONSIDERABLE NUMBER

f. How many family members, in general, who were not offenders, did you receive as clients from this agency? --->

REGIONAL SERVICES					MENTAL HEALTH				PRIVATE AGENCIES			
Charlottetown	Summerside	Montague	O'Leary	Souris	Hillsborough Hosp.	Richmond Center	Summerside	Montague	Rape Crisis Center	Protestant F.S.B.	Catholic F.S.B.	Anderson House

CHILD SEXUAL ABUSE
P.E.I. NEEDS ASSESSMENT

LAW ENFORCEMENT INSTRUMENT, MUNICIPAL POLICE DEPARTMENTS, ROYAL CANADIAN MOUNTED POLICE DETACHMENTS

May 10, 1991

J.P. Kopachevsky,
Department of Sociology,
University of Prince Edward Island,
550 University Avenue,
Charlottetown, P.E.I.,
C1A 4P3.

BACKGROUND INFORMATION

1. a). How many years of police experience do you have? Number of years ______

b). What is your current rank? ________________________________

2. a). For municipal officers:
In your years of service, how many were in:
i). general patrol ______(number of years)
ii).criminal investigations ______(number of years)

b). For RCMP:
In your years of service, how many were in:
i). highway patrol ______ (number of years)
ii). general detachment duties______(number of years)

3. What is your current municipal department or detachment?

____ (Geographic location)

4. How many years have you been in your current municipal department or been posted at your current detachment? Number of years ________________

5. a). What is your current assignment or position? ____________________

b). How long have you had these duties? ____________ years.

6. a). Your age? ____________ number of years

b). Your sex? Female _____ Male _____

EXPERIENCE IN CHILD SEXUAL ABUSE COMPLAINTS

7. a) Approximately, how many child sexual abuse complaints have you been the principal investigator in the past two years? Approximate number ____________

b) Approximately, how many child sexual abuse complaints have you assisted in the past two years? Approximate number ________________

8. If you have not investigated any cases in the past two years, approximately how many investigations have you been involved in your police career?

(Circle the appropriate number)

less than 5   6-10   11-15   16-20   21-25   25-30   31-40   41-50   51-60   60 or more

9. In the past two years, have you laid any charges in a child sexual abuse case?

Yes____ No____

If yes, approximately how many? Number _________________

TRAINING

10. Have you had any formal training or courses in the interviewing of children during criminal investigations? Yes____ No____

If yes, what kind? Please give the name of the course and a very brief description of each one.

Type 1: ____

____

Type 2: ____

____

Type 3: ____

____

11. If available, would you take more "formal" training in the following areas?

a) Techniques of investigation/interviewing children. Yes____ No____
b) Collecting/documenting evidence from children. Yes____ No____
c) The behavioural dynamics of children who have been sexually abused. Yes____ No____
d) The behavioural dynamics of families involved in sexual abuse. Yes____ No____

12. In your opinion, should officers investigating the complaints of child sexual abuse have specialized training? Yes____ No____

13. a) In your department/detachment are there any criteria or policies for assigning investigations of child sexual abuse cases? Yes____ No____ Don't know____

b) Are there identified or specific officers that are assigned to child sexual abuse cases in your department/detachment? Yes____ No____ Don't know____

14. If there are no criteria or specific persons to assign cases to, how are complaints assigned for investigation? (Briefly describe) ______________________________

____

____

15. Obviously, all officers must be willing to investigate all complaints, even those involving child sexual abuse. As with other professionals, some officers will feel "uncomfortable" and others will feel comfortable doing this type of an investigation.

In general, do you feel or would you feel comfortable or uncomfortable doing child sexual abuse investigations? comfortable____ uncomfortable____

a. If you marked "comfortable", how comfortable do you feel or would you feel doing child sexual abuse investigations?

somewhat or sort of comfortable	fairly or quite comfortable	very comfortable

b. If you marked "uncomfortable", how uncomfortable do you feel or would you feel doing child sexual abuse investigations?

somewhat or sort of comfortable	fairly or quite comfortable	very comfortable

16. a) How often have you encountered cases where children have been unwilling to provide any details in a sexual abuse investigation?

never had a case	never	once in a while	a lot of the time	almost always

b) How much difficulty have you experienced in collecting evidence from young children (under 5 years old)?

no difficulty	very little difficulty	some difficulty	quite a bit of difficulty	extreme difficulty

17. Officers will vary in their knowledge/skills of dealing with children and some of the dynamics of child sexual abuse. Please rate the adequacy of your knowledge and skills in each of the following areas.

	1 very adequate	2 quite adequate	3 somewhat adequate	4 somewhat inadequate	5 quite inadequate	6 very inadequate
a. interviewing children	1	2	3	4	5	6
b. collecting/documenting evidence from children	1	2	3	4	5	6
c. dealing with children's fears during an investigation	1	2	3	4	5	6
d. determining the validity of children's statements	1	2	3	4	5	6
e. building rapport with children during an investigation	1	2	3	4	5	6
f. determining what is an adequate interview with a child (time, depth, etc.)	1	2	3	4	5	6
g. introducing the purpose of the interview with a child	1	2	3	4	5	6
h. establishing the need to tell the truth with the child	1	2	3	4	5	6
i. using interview aids (pictures, etc)	1	2	3	4	5	6
j. using non-leading interview techniques with children	1	2	3	4	5	6
k. understanding the developmental stages of children, their language and how they respond	1	2	3	4	5	6
l. recognizing the behaviour indicators of children who have been sexually abused	1	2	3	4	5	6
m. recognizing the physical indicators of children who have been sexually abused	1	2	3	4	5	6
n. understanding the family dynamics of sexual abuse cases involving children	1	2	3	4	5	6

18. In general, how would you rate your knowledge and skills in dealing with children during investigations?

(circle your answer)

a.	very adequate	quite adequate	somewhat adequate	somewhat inadequate	quite inadequate	very inadequate

b. How would you rate your knowledge and skills in dealing with children who have been sexually abused?

never had a case	very adequate	quite adequate	somewhat adequate	somewhat inadequate	quite inadequate	very inadequate

PROTOCOLS

19. How familiar are you with the Child and Family Services Act for Prince Edward Island?

not familiar	slightly familiar	somewhat familiar	quite familiar	very familiar

20. Are you aware of the existing protocols or policy requirement involving child sexual abuse investigations? Yes____ No____. If yes, how long have you been aware of them? _______ number of years

21. a) How well do you understand the existing protocols involving child sexual abuse in Prince Edward Island?

(circle your answer)

never had to use the protocols	no understanding	a little	some	a lot	fully understand

b) In your opinion, how useful are the current protocols as they are written?

(circle your answer)

never had to use the protocols	totally useful	somewhat useful	somewhat non-useful	totally non-useful

c) In your opinion, how closely have you followed these protocols?

(circle your answer)

never had to use the protocols	not at all	a little	some	a lot	always

d) Protocols always have problems because they can never cover all kinds of situations. Please rate the level of difficulty you have had following the current child sexual abuse protocols.

(circle your answer)

never had to use the protocols	no difficulty	a little difficulty	some difficulty	a lot of difficulty	always a problem

e) If you have had difficulty, please briefly list the major problems that you've had with the current protocols. If not, please go to question 22.

1. ____________________
2. ____________________
3. ____________________
4. ____________________

22. a) Do you have any special internal procedures to follow in child sexual abuse investigations? Yes____ No____ Don't know ____

b) If yes, how well do you understand these procedures?

(circle your answer)

don't understand   slightly understand   somewhat understand   understand quite a bit   fully understand

23. In your opinion, do you need or would you need supervision in a child sexual abuse investigation? Yes____ No____

24. In you opinion, have you received adequate supervision in child sexual abuse investigations? Yes____ No____ Never had a case____

a) If you answered yes, how adequate has the supervision been?

slightly adequate   somewhat adequate   very adequate

b) If you answered no, how inadequate has the supervision been?

slightly adequate   somewhat adequate   very adequate

25. a) (Excluding CIB reporting), during a child sexual abuse investigation do you report to a supervisor within your department/detachment?

Yes____ No____ Don't know ____

b) If yes, to whom? (title only) ______________________________

c). How frequently do you report on a minor offence?

daily weekly monthly bi-monthly

d). How frequently do you report in a major offence?

daily weekly monthly bi-monthly

e). What types of things do you report? Briefly.

a) ______________________________

b) ______________________________

c) ______________________________

d) ______________________________

e) ______________________________

26. a). Do you feel that the investigation of complaints of sexual abuse require an approach (style, attitudes, etc) different than other cases? Yes____ No____

b). If yes, how different from other cases should the approach be?

(circle your answer)

slightly different	somewhat different	very different

27. In your opinion, do you feel that children who have been sexually abused have needs (emotional, social) that are different from children who have not been abused? Yes____ No____

a. If you answered yes, how different do you feel those needs are? (circle your response)

slightly different	somewhat different	very different

28. If you have been involved in child sexual abuse cases, how adequately or inadequately do you feel you have responded to the victim's needs?

never had a case	very adequate	quite adequate	somewhat adequate	somewhat inadequate	quite inadequate	very inadequate

OPINIONS ABOUT SOCIAL SERVICES

29. In your opinion, how much of an active role do you feel there is for a social worker in child sexual abuse investigations?

(circle your answer)

no active role	minor active roles	some active role	quite an active role	very active role

30. The next set of questions concern your experience with social workers during investigations. Again, this information is confidential and will be used for planning purposes only.

In your general experience,

a). how well do social workers understand the criminal code?

no understanding	very little	some	quite a bit	fully understand

b). how well do social workers understand the method and procedures of criminal investigations?

no understanding	very little	some	quite a bit	fully understand

c). how often are social workers willing to take direction from the investigating officer?

never had a case	never	seldom	sometimes	often	always

d). how would you rate the skills of social workers in child sexual abuse investigations?

never had a case	bad	poor	fair	good	excellent

e). how willing have social workers been to share information with an investigating officer in child sexual abuse investigations?

never had a case	never	seldom	sometimes	often	always

f). how willing have social workers been to share information about the victim during an investigation of child sexual abuse?

never had a case	never	seldom	sometimes	often	always

g). how willing have social workers been to share information about the offender during an investigation of child sexual abuse?

never had a case	never	seldom	sometimes	often	always

h). in general, how willing have social workers been to share roles during an investigation of child sexual abuse?

never had a case	never	seldom	sometimes	often	always

i). how much access have you had to social workers "after hours" during investigations?

no experience with them	not available	very little	some	quite a bit	always available

31. How would you rate :

a) Social Services' communication with you?

no experience with them	bad	poor	fair	good	excellent

b) Social Services' cooperation with you?

no experience with them	bad	poor	fair	good	excellent

32. a) Do you personally feel that "therapy or counselling" of child witnesses contaminates the evidence that you have collected or are collecting in a child sexual abuse case? Yes____ No____ Don't know____

b) If yes, how much?

very little	some	a lot	very much

33. There are expectations on an officer's work during the investigation of child sexual abuse cases. There are things that they can and cannot do. In other words, some of the expectations are realistic and others are not.

If you never had a case or assisted in the investigation of a child sexual abuse case, please go to question 35.

a) How realistic or unrealistic have the expectations been by the following people during a child sexual abuse case? In other words, what they think you can or able to do.

	1 very realistic	2 somewhat realistic	3 somewhat unrealistic	4 very unrealistic
1. victims	1	2	3	4
2. parents (non-offending)	1	2	3	4
3. social workers	1	2	3	4
4. prosecutor	1	2	3	4
5. community, in general	1	2	3	4
6. supervisors	1	2	3	4

34. During child sexual abuse cases, problems will arise between the investigating officer and the prosecutor's office. They may involve evidence, distance to the prosecutor, delivery of evidence, lack of supervision, etc.

What are the major difficulties that you have encountered with the Crown Prosecutor's office in child sexual abuse cases?

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

e. ______________________________

35. In general, after a case has been assigned to you, how willing would you be to do the following things?

	1 not	2 slightly	3 somewhat	4 quite	5 very
a). to request assistance from Social Services during an investigation of child sexual abuse when the offender is in the family?	1	2	3	4	5
b). to request assistance from Social Services during an investigation of child sexual abuse when the offender is outside the family?	1	2	3	4	5
c). to share roles with a social worker during an investigation?	1	2	3	4	5

	not	slightly	somewhat	quite	very
d). to plan an investigation with a social worker?	1	2	3	4	5
e). to share information about an investigation?	1	2	3	4	5
f). to protect a social worker during an investigation?	1	2	3	4	5

36. For officers who have had handled or assisted in child sexual abuse investigations: In your opinion, what are the four most frustrating aspects of doing investigations and handling cases that involve child sexual abuse?

Please list:

a) ____

b) ____

c) ____

d) ____

Thank you for your assistance!

Joe Kopachevsky.

JUSTICE SURVEY

The role and practice of the Justice system is important in a comprehensive system of child sexual abuse. This survey is interested in receiving your perspective in the development of a model of child sexual abuse. The survey will address a number of areas including the processes within the court, the various programs both within and outside the Justice system as well as your role within the system.

1. Approximately how many cases of child sexual abuse have you dealt with? _____

2. As compared to most cases which you deal with, how complicated/complex do you find child sexual abuse cases?

(circle your response)

1	2	3	4	5
much more complicated	somewhat more complicated	about the same	somewhat less complicated	much less complicated

3. In your opinion, is there a need for specialized knowledge in dealing with cases of child sexual abuse? Yes____ No____. Please explain.

4. The following is a list of knowledge/skill areas. Please indicate (A) whether you have formal training in these areas and (B) whether you would like further training/knowledge.

	taken training A	like to B
1. general knowledge about child sexual abuse	_____	_____
2. dynamics of child sexual abuse	_____	_____
3. general knowledge about child development	_____	_____
4. impact of child sexual abuse in the victim	_____	_____
5. physical/behavioral indicators of child sexual abuse	_____	_____
6. dynamics and role of families in child sexual abuse	_____	_____
7. knowledge about adult sex offenders and offenses	_____	_____
8. adolescent sex offenders	_____	_____
9. available assessment service for victims, families and offenders	_____	_____
10. available treatment services for victims, families and offenders	_____	_____

5. The following knowledge/skill areas deal with the court process. Please indicate (A) whether you have taken formal training and (B) if you are interested in further information or training in each of these areas.

	taken training A	like to B
1. how developmental issues impact in child's recall	_____	_____
2. how developmental issues impact on child's testimony	_____	_____
3. impact of various ages on understanding/competence	_____	_____
4. impact of the court experience on children re: 1,2,3	_____	_____
5. general impact of the court experience on children	_____	_____
6. knowledge of legal issues concerning child sexual abuse	_____	_____
7. preparation techniques for child witnesses	_____	_____
8. interview skills with children	_____	_____
9. providing supportive experiences for children	_____	_____
10. crisis intervention with families and children	_____	_____
11. knowledge of effectiveness of treatment with:		
a. victims	_____	_____
b. families	_____	_____
c. adult sex offenders	_____	_____
d. adolescent sex offenders	_____	_____
12. impact of sentences on offenders	_____	_____
13. impact of treatment on offenders	_____	_____

7. What would be the best way for you to learn this information/skills? For example, in what format, with what groups, times, etc.

____

____

____

____

____

8. For each of the following issues, please rate how much of a problem you believe it is in the legal system on Prince Edward Island, using the following scale:

0	1	2	3	4
not a problem	minor problem	moderate problem	major problem	don't know

	not a problem	minor problem	moderate problem	major problem	don't know
1. length of time for case to go to court	0	1	2	3	4
2. length of time to complete cases	0	1	2	3	4
3. preparation of children for court by:					
a. Victim Services	0	1	2	3	4
b. Crown Prosecutor	0	1	2	3	4
4. court system is not child centred	0	1	2	3	4
5. too many barriers to prosecution	0	1	2	3	4
6. Crown too rushed/crisis oriented in preparation of cases	0	1	2	3	4
7. belief that therapy for child "taints" evidence	0	1	2	3	4
8. lack of specialized knowledge and training in dealing with these cases	0	1	2	3	4
9. sentencing focuses too much on offender's needs and not enough on impact on victim	0	1	2	3	4

	not a problem	minor problem	moderate problem	major problem	don't know
10. court procedures aren't flexible enough for child witnesses	0	1	2	3	4
11. inadequacy of victim impact statements	0	1	2	3	4
12. ineffective use of victim impact statements in sentencing	0	1	2	3	4
13. sentences are too lenient	0	1	2	3	4
14. lack of support for victim during the court process	0	1	2	3	4
15. lack of support/explanation to child following completion of court	0	1	2	3	4
16. prosecution of cases with very young children	0	1	2	3	4
17. not enough use of expert witnesses in court	0	1	2	3	4
18. not enough input from therapists, workers in pre-sentencing report	0	1	2	3	4
19. child sexual abuse cases not enough of a priority	0	1	2	3	4
20. false allegations of sexual abuse	0	1	2	3	4
21. police investigations not sufficiently prepared	0	1	2	3	4
22. Crown cases not sufficiently prepared	0	1	2	3	4
23. availability of specialized treatment for victims	0	1	2	3	4
24. availability of specialized treatment for offenders	0	1	2	3	4
25. coordination with other agencies	0	1	2	3	4

9. For those issues that you identified as a "major" or "moderate" problem, please offer your suggestions of what could be done on P.E.I. to address them.

1. Issue #______ ____

____

____

2. Issue #______ ____

____

____

3. Issue #______ ____

____

____

4. Issue #______ ____

____

____

10. While the previous list covers issues across the legal system, other problems have been identified specifically for those child victims who go through the legal process. Please rate how much you perceive each of the following as a problem for these child victims on P.E.I.

	0 not a problem	1 minor problem	2 moderate problem	3 major problem	4 don't know
1. length of court process	0	1	2	3	4
2. delays, postponements in hearings	0	1	2	3	4
3. fear/anxiety as court approaches	0	1	2	3	4
4. cross examination by defence counsel	0	1	2	3	4
5. facing the accused in the court building before the trial	0	1	2	3	4
6. facing the accused in court	0	1	2	3	4
7. courtroom environment is intimidating to children	0	1	2	3	4
8. physical circumstances of giving testimony (height of chairs, making oneself heard)	0	1	2	3	4
9. being on the witness stand for long periods without a break	0	1	2	3	4
10. understanding court procedures	0	1	2	3	4
11. court is open to the public	0	1	2	3	4
12. understanding and accepting not guilty verdicts	0	1	2	3	4
13. understanding and accepting more lenient sentences (e.g. suspended sentences, short sentences)	0	1	2	3	4
14. accused out on bail contacting the victim and family	0	1	2	3	4
15. removal of victim from home rather than accused	0	1	2	3	4
16. feeling believed in court	0	1	2	3	4

11. The following are some suggestions that have been offered to help address some of the problems children may experience in court. For each suggestion, please indicate whether you agree or disagree with their use for child sexual abuse cases in P.E.I. courts.

1	2	3	4	5	6
disagree strongly	disagree somewhat	disagree a little	agree a little	agree somewhat	agree strongly

1. development of private waiting spaces for victims	1	2	3	4	5	6
2. use of privacy screens for child witnesses	1	2	3	4	5	6
3. give precedence on the trial schedule for child sexual abuse cases	1	2	3	4	5	6
4. permit use of videotaping of testimony	1	2	3	4	5	6
5. eliminate the corroborative requirement and enact the ability to communicate test	1	2	3	4	5	6
6. allow a supportive adult to sit with the child during testimony	1	2	3	4	5	6
7. allow a child witness to have breaks during testimony	1	2	3	4	5	6
8. provide a booster chair for child witnesses	1	2	3	4	5	6
9. provide microphones for child witnesses	1	2	3	4	5	6
10. use of closed circuit television for giving testimony	1	2	3	4	5	6
11. use of expert witnesses concerning impact of abuse on victim	1	2	3	4	5	6
12. use of expert witnesses concerning ability of child witnesses to testify	1	2	3	4	5	6
13. use of orders to prohibit accused from contacting the victim	1	2	3	4	5	6
14. use of court orders to remove accused from family home rather than the victim	1	2	3	4	5	6

12. Please list any other ideas you have for making the legal process better for child victims.

a. ______________________________

____

____

b. ______________________________

____

____

c. ______________________________

____

____

THANK YOU VERY MUCH. PLEASE RETURN THE COMPLETED QUESTIONNAIRE IN THE ENCLOSED ENVELOPE.

CASE REQUIREMENTS

(Time Estimates)

A. Three Child Welfare Services cases of child sexual abuse will be chosen from each of the regional services centres in Charlottetown, Summerside and Montague.

B. Of the three cases chosen from each centre, one should be a "light" case or relatively easy case in terms of time demand. The second should be a "moderate" or an average case and the third should be a "heavy" case or one that was difficult or demanding.

C. Each agency that was involved with each case will make a short but inclusive list of the activities and services provided to that client. Then, an estimate of time spent in those activities should be estimated. The major concern is the total time spent on each particular case. The list of activities will help to understand that total time.

D. Estimate sheets of those same cases will then be provided to:
   1. Child Welfare Supervisor of each case
   2. the Police Officers involved in that case
   3. the Prosecutor involved with the case
   4. the Victim Services worker (including court)
   5. the Therapist involved in the case
   6. other service agencies involved in the case
   7. volunteer agencies involved in the case

E. In estimates of hours required, be sure to include time spent in contact with people outside your agency.

CHARLOTTETOWN - LIGHT CASE

SOCIAL SERVICES:

CFS Intake activities:	Estimated hours required
a. ____________________	____________
b. ____________________	____________
c. ____________________	____________
d. ____________________	____________
e. ____________________	____________
Subtotal:	____________

Long term activities:	Estimates hours required:
a. ______________________________	______________
b. ______________________________	______________
c. ______________________________	______________
d. ______________________________	______________
e. ______________________________	______________
Subtotal:	______________

Other services used: Estimated hours required:

a. ______________________________ ______________

b. ______________________________ ______________

c. ______________________________ ______________

d. ______________________________ ______________

e. ______________________________ ______________

Subtotal: ______________

Other activities (not listed):	Estimated hours required:
a. ______________________________	______________
b. ______________________________	______________
c. ______________________________	______________
d. ______________________________	______________
e. ______________________________	______________
Subtotal:	______________

Estimated total hours __________

CHARLOTTETOWN - LIGHT CASE

POLICE:

Activities list:	Estimated hours required
a. ____________________	__________
b. ____________________	__________
c. ____________________	__________
d. ____________________	__________
e. ____________________	__________
f. ____________________	__________
g. ____________________	__________
h. ____________________	__________
i. ____________________	__________
Subtotal:	__________

Other resources or services required:	Estimated hours required:
a. ______________________________	______________
b. ______________________________	______________
c. ______________________________	______________
d. ______________________________	______________
e. ______________________________	______________
f. ______________________________	______________
g. ______________________________	______________
h. ______________________________	______________
Subtotal:	______________

Total estimated hours __________

CHARLOTTETOWN - LIGHT CASE

PROSECUTOR'S OFFICE:

Pre-court activities:	Estimated hours required
a. ______________________________	______________
b. ______________________________	______________
c. ______________________________	______________
d. ______________________________	______________
e. ______________________________	______________
Subtotal:	______________

Court activities:	Estimated hours required:
a. ______________________________	______________
b. ______________________________	______________
c. ______________________________	______________
d. ______________________________	______________
e. ______________________________	______________
Subtotal:	______________

Total estimated hours __________

CHARLOTTETOWN - LIGHT CASE

VICTIM SERVICES AND COURT:

Activities list:	Estimated hours required
a. ____________________	__________
b. ____________________	__________
c. ____________________	__________
d. ____________________	__________
e. ____________________	__________
Subtotal:	__________

Court - Judge:	Estimated hours required:
a. ______________________________	______________
b. ______________________________	______________
c. ______________________________	______________
d. ______________________________	______________
e. ______________________________	______________
Subtotal:	______________

Court - Others (including defence): Estimated hours required:

a. ______________________________ ______________

b. ______________________________ ______________

c. ______________________________ ______________

d. ______________________________ ______________

e. ____________________ ___________ ______________

Subtotal: ______________

Total estimated hours: ______________

CHARLOTTETOWN - LIGHT CASE

MENTAL HEALTH SERVICES:

I. Individual activities list:

Estimated hours required:

a. ____________________ ____________

b. ____________________ ____________

c. ____________________ ____________

d. ____________________ ____________

e. ____________________ ____________

f. ____________________ ____________

g. ____________________ ____________

Subtotal: ____________

II.	Group activities list:	Estimated hours required:
	a. ______________________________	______________
	b. ______________________________	______________
	c. ______________________________	______________
	d. ______________________________	______________
	e. ______________________________	______________
	f. ______________________________	______________
	Subtotal:	______________

Total estimated hours: ______________

CASE STATUS: Still open ____ Closed ____

III. Other services or other resources required:

a. ______________________________ for how long? __________

b. ______________________________ for how long? __________

c. ______________________________ for how long? __________

d. ______________________________ for how long? __________

e. ______________________________ for how long? __________